NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM
DEPARTMENT OF SERVICES • DEPARTMENT OF REGULATION AND LICENSURE
DEPARTMENT OF FINANCE AND SUPPORT

STATE OF NEBRASKA
MIKE JOHANNS, GOVERNOR

November 24, 2003

Ms. LouEllen M. Rice, Grants Management Officer
SAMHSA Office of Program Services
Division of Grants Management
Room 13-103 Parklawn Building
5600 Fishers Lane
Rockville, MD 20857

Dear Ms. Rice

Enclosed please find an original and two copies of the "Nebraska State Plan Implementation Report for FY2003". This report includes Nebraska's submission of Section IV Implementation Report and Section V Uniform Data per the requirements of the Community Mental Health Services Block Grant, Application Guidance and Instructions, FY2003-2004.

The Nebraska Department of Health and Human Services (HHS) Office of Mental Health, Substance Abuse and Addiction Services is responsible for preparing this report. The Mental Health Planning and Evaluation Council (State Mental Health Planning Council) reviewed the report on November 18, 2003.

If you have questions do contact me, or Jim Harvey (telephone: 402-479-5125; fax: 402-479-5162; e-mail: jim.harvey@hhss.state.ne.us).

Sincerely,

Ronald E. Sorensen, Administrator
Office of Mental Health, Substance Abuse and Addiction Services
Nebraska Department of Health and Human Services

Cc: Richard DiGeronimo, State Planning and Systems Development Branch
Center for Mental Health Services, U.S. Department of Health and Human Services



PO Box 98925
LINCOLN, NE 68509-8925

**NEBRASKA COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT**

# "Nebraska State Plan Implementation Report for FY2003".

**Nebraska Department of Health and Human Services**
**Office of Mental Health, Substance Abuse and Addiction Services**

**Page**



The Nebraska State Plan Implementation Report is prepared to address the requirements under Section 1942(a) of the PHS Act (42 U.S.C. 300x-52). This report is due to the Federal Center for Mental Health Services by December 1, 2003.

The Mental Health Planning and Evaluation Council (State Mental Health Planning Council) reviewed the report on November 18, 2003.

Send questions or comments on this report to:


Jim Harvey
Nebraska Department of Health and Human Services (HHS)
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Lincoln, NE 68509-8925
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## SECTION ONE:
## FY2003 EXPENDED BY SERVICE TYPE AND RECIPIENTS OF FUNDS

**Report Summary Community Mental Health Services Block Grant —
FY2003 Expended By Service Type and Recipients of Funds**

This section reports on:

1. the purposes for which the block grant monies for State FY 2003 were expended,
2. the recipients of funds provided under the grant, and
3. description of activities using the funds.

This is the report on the spending of the FY2003 Mental Health Block Grant funds. Most of this report is from the point of view of the direct contractors, that is, the six Regional Governing Boards under contract with the HHS Office of Mental Health, Substance Abuse and Addiction Services.

The application for FY2003 showed how the HHS Office of Mental Health, Substance Abuse and Addiction Services allocated the Federal Mental Health Block Grant funds in the FY2003 contracts with the Regional Governing Boards. The tables below report how the six Regional Governing Boards used the federal mental health block grant funds. Specifically, it is the "Report of Revenues and Expenditures" (Actuals) prepared by each of the six Regional Governing Boards August 29 to September 3, 2003 and submitted to HHS. The regions' reports of actuals for FY2003 are useful in showing self reported pattern for expenditures.

1. **The purposes for which the block grant monies for State FY 2003 were expended**

The final allocation for FY2003 Community Mental Health Services Block Grant was $2,099,881.

| | |
|---|---|
| $2,042,087 | FY2003 base |
| $ 57,794 | increase (notice received May 5, 2003). |
| $2,099,881 | Final Allocation |

- Adult Residential, Rehab, and Support Services
  Community Support, Day Rehabilitation, Vocational Support, Day Support, and Psychiatric Residential Rehabilitation. Please note that two Day Support programs hire consumers as employees (Peer Specialist) with federal mental health block grant funds.

- Adult Treatment Services
  Outpatient therapy, Medication Management, Day Treatment

- Children's Services
  Professional Partner, Professional Partner / School Wrap Around, Day Treatment, Therapeutic Consultation and Intensive Outpatient.

Other uses included Peer Review ($3,200), Rural Service Equity ($54,907) and the 5% State Administration allocation used to Empower Consumers ($104,994) for a total of $163,101.

Rural Service Equity funds are unallocated at this time. Allocation occurs as needed to rural areas.

2. **Recipients of the Mental Health Grant Funds** are the six Regional Governing Boards.

According to the Nebraska Comprehensive Community Mental Health Services Act (Neb. Rev. Stat. 71-5001 to 71-5014), the six mental health regional governing boards shall offer comprehensive community mental health, drug abuse, and alcoholism programs, services, and facilities (section 71-5009). The Nebraska Department of Health and Human Services (HHS) Office of Mental Health, Substance Abuse, and Addiction Services is the State Mental Health Authority. HHS contracts with the six Regional Governing Boards to purchase community mental health services.

The Nebraska Comprehensive Community Mental Health Services Act established regions by dividing the state into six geographic service areas. Each region is a political subdivision of local government, directed by a board composed of one county commissioner from each of the counties represented in the region. Each of these service areas has one Regional Governing Board (RGB) formed by an interlocal agreement and whose members are made up of these county commissioners.

Overall expenditures, based on the "Report of Actuals" from the Regional Governing Boards were

Region 1.....$148,251.....(8.5%)
Region 2.....$138,737.....(7.9%)
Region 3.....$225,346.....(12.9%)
Region 4.....$265,468.....(15.2%)
Region 5.....$385,759.....(22.1%)
Region 6.....$583,228.....(33.4%)
Total.....$1,746,789.....(100.0%)

Based on the "Report of Actuals" from the Regional Governing Boards, the overall picture for services purchased for adults and for children:

| | | |
|---|---|---|
| Adult Residential, Rehab, and Support Services | $487,325 | 27.90% |
| Adult Treatment Services | $557,144 | 31.90% |
| Children's Services | $702,320 | 40.20% |
| Total | $1,746,789 | 100% |

Based on the "Report of Actuals" from the Regional Governing Boards (September 2003)

**State Summary / Regional Governing Board "Report of Actuals" FY2003**

| | REGION | 1 | 2 | 3 | 4 | 5 | 6 | TOTAL | % of Total |
|---|---|---|---|---|---|---|---|---|---|
| **SERVICES** | | | | | | | | | |
| **Adult Residential, Rehab, and Support Services** | Comm. Support – MH | | $22,814 | $15,240 | $33,094 | | $10,944 | $82,092 | 4.7 |
| | Day Rehabilitation | | $30,419 | | | | $22,176 | $52,595 | 3.0 |
| | Psych Resid Rehab | | | | | | $131,400 | $131,400 | 7.5 |
| | Vocational Support | $1,440 | $55,504 | $15,534 | $38,800 | $20,000 | | $131,278 | 7.5 |
| | Day Support | $33,360 | | $41,600 | | | | $74,960 | 4.3 |
| | Dual Resid (SPMI/CD) | | | | | $15,000 | | $15,000 | 0.8 |
| | **Subtotal** | $34,800 | $108,737 | $72,374 | $71,894 | $35,000 | $164,520 | $487,325 | |
| **Adult Treatment Services** | Day Treatment | | | | | $20,000 | | $20,000 | 1.1 |
| | OP Assess&Ther– MH | $29,419 | | $53,147 | $36,013 | $144,000 | $173,708 | $436,287 | 25.0 |
| | Med. Management | $6,032 | | $49,825 | | | $45,000 | $100,857 | 5.8 |
| | **Subtotal** | $35,451 | | $102,972 | $36,013 | $164,000 | $218,708 | $557,144 | |
| **Children's Services** | Prof Partner | | $30,000 | $50,000 | $157,561 | $150,921 | $200,000 | $588,482 | 33.7 |
| | Prof Part / School Wrap | $78,000 | | | | | | $78,000 | 4.5 |
| | Intensive Outpt | | | | | $35,838 | | $35,838 | 2.1 |
| | **Subtotal** | $78,000 | $30,000 | $50,000 | $157,561 | $186,759 | $200,000 | | |
| | **TOTALS** | $148,251 | $138,737 | $225,346 | $265,468 | $385,759 | $583,228 | $1,746,789 | 100.0 |
| % of Total | | 8.5 | 7.9 | 12.9 | 15.2 | 22.1 | 33.4 | 100 | |

Region 1 Regional Youth System coordination $38,000 not included.
Region 2 Regional Youth System coordination $15,000 not included.
Region 3 Regional Youth System coordination $42,856 not included.
Region 4 Capacity Access Guarantee $788 not included.
Region 5 Regional Youth System coordination $73,000 not included.

**Small Increase**

The Nebraska State Plan for Comprehensive Community Mental Health Services for the Fiscal Year 2003 was modified. It was in reaction to the letter from Dr. Joyce Berry, received May 5, 2003 raising the state's allocation by $57,794. Five percent is for administration ($2,890). The balance for purchasing services is $54,904.

Nebraska plan was to use the $54,904 for rural equity. This means the increase will be used to attempt to improve the distribution of federal and state mental health funds consistent with the per capita and income rates reported for each Region. To do this, after the FY2004 contract amounts are determined, these funds will be allocated in such a manner to work toward equalizing the distribution of the Federal Mental Health Block Grant funds by geographic area for adults with Serious Mental Illness (SMI) and youth with serious emotional disturbances (SED).

At this point, it is anticipated to be contracted with Region 2 Governing Board for additional services for SMI or SED. That should help them come up to the allocation formula percentage they should have.

**Nebraska Accounting System**
The State of Nebraska Accounting System uses the "Cash Basis" of Accounting. When looking at expenditures of funds from that point of view, one needs to keep in mind that, in general, there is a lag time for the cash to flow in the form of payment for services.

On the cash basis, as of June 30, 2003, FY2003 Federal Mental Health Block Grant

| | |
|---|---|
| Authorized Amount ..... | $1,574,910 |
| Unexpended ..... | $1,149,810.11 |
| Expended..... | $ 425,099.89 |
| | $ 2,525.33 for Administration (Consumer Empowerment) |
| | $ 422,574.56 for Aid. |

Most of June services were yet to be paid, so this actual spending did not reflect the billings unpaid.

As of September 30, 2003, the Nebraska Accounting System paid from the FY2003 MH Block Grant on a cash basis was:

| | |
|---|---|
| Authorized Amount ..... | $2,099,881 |
| Unexpended ..... | $1,178,827.17 |
| Expended..... | $ 921,053.83 |
| | $ 8,654.43 for Administration (Consumer Empowerment) |
| | $ 912,399.40 for Aid. |

Spending (on a cash basis) during the July 1 through Sept. 30, 2003 quarter totaled $495,953.94. Please note again, that this doesn't include any unpaid obligations due after September 30, 2003.

## SECTION TWO:
## SUMMARY OF SIGNIFICANT EVENTS

### 1. STATE BUDGET CUTS

According to the Lincoln Journal Star on November 21, 2003, the current estimated State budget shortfall is $211 million. That is the number Nebraska lawmakers will have to come up with in cuts, taxes, cash reserve transfers or other actions to finish the two-year budget cycle in balance.

STATE COMMUNITY MENTAL HEALTH AID SAME AS LAST YEAR – The Legislature needed to make massive cuts to the State of Nebraska budget. However, the state aid for FY2004 community mental health remained the same as previous fiscal year.

The financial resources in the Nebraska Department of Health and Human Services have been reduced significantly over the last few years. The situation is getting worse. However, the Nebraska overall goal is to at least maintain operations, seeking ways to improve services within the limited resources available to the Nebraska Behavioral Health System (NBHS) consistent with the intent of the Governor and Legislature.

As reported in the Nebraska FY2004 Community Mental Health Services Block Grant Application, there were two special sessions and one regular session of the Nebraska Legislature. The Legislature and Governor cut the state budget by $477 million in the special session in October 2001, the 2002 regular session, and the Summer 2002 session.

On January 15, 2003, Governor Mike Johanns said in his "State of the State Address"
- "... 2002 tax receipts were truly historic – on the down side." and
- "... the Legislative Fiscal Office defines our dilemma as a $673 million dollar difference in projected spending needs and projected revenue over the next two years. That number is conservative. Deficit requests and a potential liability arising out of the Boyd County Low-Level Radioactive Waste Site litigation balloons this number to a staggering $850 million dollars."

Governor Johanns referred to “Boyd County Low-Level Radioactive Waste Site litigation”. This litigation refers to the $151million, plus interest that could be due to the five-state compact (Nebraska, Louisiana, Arkansas, Oklahoma and Kansas) for the money spent on building the low-level nuclear waste dump warehouse in Boyd County, Nebraska. The $151 million is based on the ruling by U.S. District Court Judge Richard Kopf on September 30, 2002 that Nebraska state officials denied for political reasons a license to build the low-level nuclear waste dump warehouse in Boyd County.

According to media reports (Newspaper - Lincoln Journal Star: May 15, 2003; May 18, 2003; May 31, 2003; June 20, 2003; June 21, 2003; June 27, 2003; July 15, 2003; July 18, 2003; July 19, 2003; July 28, 2003; August 11, 2003; August 12, 2003)
- The state collected less money in fiscal year 2002 than in either of the two previous years, and state government faced a $750 million budget problem over the next two years.
- Sales, income and miscellaneous taxes collected for the fiscal year 2003 were $49.6 million below official forecasts, according to the state Department of Revenue. Receipts were off 11.1 percent in June 2003 alone.
- The annual budget for the State of Nebraska is about $2.6 billion.
- The 2003 Legislature finalized two-year budget for $5.4 billion.

- To address the $750 million budget shortfall, the Legislature cut funding for more than 30 state agencies, including the University of Nebraska.
- The Legislature raised $343 million in tax increases.
- State tax revenues are below projections for July, the first month of the 2004 fiscal year. The state's net tax revenues were $8 million (4.5 percent) below projections for the month.
- At least 640 state full-time-equivalent positions have been eliminated in budget cuts over almost two years.
- A major part of the bill that passed eliminates Medicaid coverage for 19- and 20-year-olds who live alone and make less than $392 a month, known as "Ribicoff" coverage. The state estimates that more than 3,100 low-income young adults statewide will lose Medicaid eligibility

A $58 million infusion of extra federal funds and plans to use a special cash reserve fund to pay bills during the summer months will help for the next six months. But if the economy and the tax revenue situation don't improve this fall, senators will once again be looking to cut state funding. Governor Johanns expected the state would face difficult cash flow issues in fiscal year 2004.

The Omaha, Grand Island, Lexington and South Sioux City public schools are suing the state, claiming the funding formula is unfair and inadequate. The lawsuit was filed after the state legislature cut aid to public schools this spring by 3 percent and modified the formula, resulting in a loss of money to these school districts. The Nebraska Constitution says the state must provide an equal public education for all students. However, there is also an ongoing discussion regarding the role of the state versus local control.

At the June 12, 2003 MHPEC meeting, Frank Lloyd, Director of Nebraska Vocational Rehabilitation reported that they took a 5% state general fund budget cut.

STATE COMMUNITY MENTAL HEALTH AID SAME AS LAST YEAR – The Legislature needed to make massive cuts to the State of Nebraska budget. However, the state aid for FY2004 community mental health remained the same as previous fiscal year.

Drought Continues to Impact the Nebraska Economy

From the Nebraska Climate Assessment Response Committee meeting on January 30, 2003:

- Virtually every statistical summary was a reminder of what happened last year and what will get worse without a major shift in weather patterns.
- State Climatologist Al Dutcher said if the rains don't come the situation last year will pale in relation to what we will face this year.
- Mark Svoboda with the National Drought Mitigation Center at the University of Nebraska-Lincoln said Nebraska last year endured the driest period since the Dust Bowl of the 1930s, and prospects for above-normal precipitation between February and April are weak at best.
- 2002 ended with the third-lowest annual precipitation on record and $1.2 billion in economic impact on the state's agricultural sector.

As of August 24, 2003, according to media reports (Lincoln Journal Star, page C1), drought still grips Nebraska. All of the state is listed in some level of drought, ranging from abnormally dry in the northeast to extreme drought in the southwest.

October 11, 2003 Lincoln Journal Star reported Governor Johanns predicting budget shortfalls of $150 million to 200 million. Tax receipts continue to fall below revenue forecasts.

**2 LB 724**

**Nebraska Behavioral Health Reform Act (LB724)**
LEGISLATIVE BILL 724 was approved by the Governor on May 13, 2003. The purpose of the "Nebraska Behavioral Health Reform Act" is to state legislative intent for reform of the behavioral health system and for a substantive recodification of statutes relating to the funding and delivery of behavioral health services in the State of Nebraska. The Legislature finds that:

(1) The separate and distinct funding and administrative mechanisms of the regional centers and the county regional governance system present significant barriers to statewide coordination of the behavioral health system;
(2) The number of inpatients at the regional centers is significantly less than the originally designed capacity of such centers and many regional center buildings are uninhabitable or require significant expenditures of state funds for maintenance and renovation;
(3) The size and scope of the administrative bureaucracy in each behavioral health region has significantly expanded since passage of the Nebraska Comprehensive Community Mental Health Services Act and each regional governing board both provides behavioral health services and administers state and other funds for the provision of such services;
(4) The availability of community-based behavioral health services in the State of Nebraska is inadequate to meet the need for such services; and
(5) Many persons with behavioral health disorders are admitted for inpatient treatment when outpatient treatment would be a clinically appropriate and less restrictive treatment alternative for such persons, mental health board commitments lack uniformity statewide, and persons are frequently retained in emergency protective custody after being committed for treatment by a mental health board and prior to the commencement of such treatment.

Sections 5 to 8 of this act discuss the intent of the Legislature to revised and recodified statutes related to the:

- regional centers (section 5)
- county regional governance system (section 6)
- statewide administration and funding of the behavioral health system (Section 7)
- Nebraska Mental Health Commitment Act (Section 8).

Section 9 says the chairperson of the Health and Human Services Committee of the Legislature shall prepare and introduce legislation or amendments to legislation in the Ninety-eighth Legislature, Second Session, to implement sections 5 to 8 of this act.

Section 10 amended Section 83-1079 regarding the mental health commitment boards

In the Lincoln Journal Star (June 9, 2003), Governor Mike Johanns said, if he was forced to pick just one area he could influence during his remaining days as Governor, it would be **mental health**.

In that same article Omaha Senator Jim Jensen, Chair of the Health and Human Services Committee of the Nebraska Legislature, said he is looking for ways to provide more housing and treatment services in local communities and examine the need for three regional centers.

Both Senator Jensen and Governor Johanns were involved in "Nebraska Behavioral Health Reform Act" (**LEGISLATIVE BILL 724**). This bill was approved by the Governor on May 13, 2003. The purpose of this Act is to state legislative intent for reform of the behavioral health system and for a

substantive recodification of statutes relating to the funding and delivery of behavioral health services in the State of Nebraska.

Senator Jensen, as the chairperson of the Health and Human Services Committee of the Legislature, is to prepare and introduce legislation or amendments to legislation in the Ninety-eighth Legislature, Second Session (Spring 2004 session).

As noted in Section II – D (Legislative initiatives), the next indicator of this work, as stated in LB724 Section 9 is for the chairperson of the Legislature's Health and Human Services Committee will prepare and introduce legislation in the next session (2004).

**Rough Draft of Implementing Legislation as of November 19, 2003**
Below is the Rough Draft of Implementing Legislation for Behavioral Health System Reform (LB 724) issued on November 19, 2003 by Senator Jim Jensen, Chair, Health and Human Services Committee, Nebraska Legislature [(402) 471-2622 / jjensen@unicam.state.ne.us].

## Short Title

Section 1. (cf. 71-5001) Sections 1 to X of this act shall be known and may be cited as the Nebraska Behavioral Health Services Act.

## Purpose

Sec. 2. The purposes of the Nebraska Behavioral Health Services Act are to: (1) reorganize statutes relating to the provision of publicly funded services to persons with behavioral health disorders; (2) provide for the organization and administration of the public behavioral health system within the department; (3) rename mental health regions as behavioral health regions; (4) provide for the establishment of regional behavioral health authorities and ongoing activities of regional governing boards; (5) reorganize the State Mental Health Planning and Evaluation Council, the State Alcoholism and Drug Abuse Advisory Committee, and the Nebraska Advisory Commission on Compulsive Gambling into a single State Behavioral Health Advisory Council; (6) change and add provisions relating to development of community-based behavioral health services and funding for behavioral health services; and (7) provide for the closure of two regional centers.

## Legislative Intent/Policy

Sec. 3. (1) The purposes of the public behavioral health system are to ensure: (a) statewide access to behavioral health services; (b) high quality behavioral health services; (c) cost-effective behavioral health services; and (d) the public safety.

(2) Statewide access to behavioral health services includes, but is not limited to: (a) adequate availability of behavioral health providers, programs, and facilities; and (b) an appropriate array of community-based services and continuum of care for persons with behavioral health disorders.

(3) High quality behavioral health services includes, but is not limited to: (a) services that reflect best practices and emphasize prevention, early intervention, recovery, and integration with primary health care services; (b) appropriate treatment planning, beneficial treatment outcomes, peer support, and case management for consumers; (c) appropriate regulation of behavioral health providers, programs, and facilities; and (d) consumer involvement as a priority in all aspects of service planning and delivery.

(4) Cost-effective behavioral health services includes, but is not limited to: (a) services that are efficiently managed and supported with appropriate funding, planning, and

information; and (b) funding that follows the consumer and supports his or her plan of treatment.

## Definitions

Sec. 4. (cf. 71-5002) For purposes of the Nebraska Behavioral Health Services Act:

(1) Administrator means the administrator of the division of behavioral health services within the department;

(2) Behavioral health disorder means mental illness or alcoholism, drug abuse, or other addictive disorder;

(3) Behavioral health region means a behavioral health region established in section 6 of this act;

(4) Behavioral health services means services provided for the prevention, diagnosis, early intervention, and treatment of behavioral health disorders and the recovery of persons affected by such disorders;

(5) Community-based behavioral health services or community-based services means inpatient or outpatient behavioral health services that are not provided at a regional center;

(6) Department means the Department of Health and Human Services;

(7) Director means the Director of Health and Human Services;

(8) Division means the administrative division for behavioral health services within the department;

(9) Nebraska Health and Human Services System means the Department of Health and Human Services, the Department of Health and Human Services Regulation and Licensure, and the Department of Health and Human Services Finance and Support;

(10) Policy Cabinet means the Policy Cabinet of the Nebraska Health and Human Services System established in section 81-3009;

(11) Public behavioral health system means the statewide array of behavioral health services provided by the public or private sector and supported in whole or in part with funding received and administered by the Nebraska Health and Human Services System, including behavioral health services provided under the medical assistance program established in section 68-1018;

(12) Regional administrator means the administrator of a regional behavioral health authority appointed pursuant to section 7 of this act;

(13) Regional behavioral health authority means a regional behavioral health authority established pursuant to section 7 of this act; and

(14) Regional center means one of the state hospitals for the mentally ill designated in section 83-305.

(15) Regional governing board means the governing board of a regional behavioral health authority as provided in section 7 of this act.

## State Leadership

Sec. 5. (cf. 71-5003) (1) The director shall establish and maintain a separate administrative division for behavioral health services within the department. The division shall establish and maintain a separate budget and shall separately account for all revenues and expenditures.

(2) The administrator of the division shall be appointed by the Governor and confirmed by a majority of members of the Legislature. The director shall appoint a clinical officer and a program administrator for consumer affairs for the division. The administrator shall report to the director and shall be responsible for administration and management of

the division. The clinical officer and the program administrator for consumer affairs shall report to the administrator.

(3) The administrator, in consultation with consumers and consumer advocates, shall establish and maintain an office of consumer affairs within the division, which shall be directed by the program administrator for consumer affairs.

(4) The division shall act as the chief behavioral health authority for the State of Nebraska and shall direct the administration and coordination of the public behavioral health system, including but not limited to: (a) administration and management of the division, regional centers, and any other facilities and programs operated by the division; (b) integration and coordination of the public behavioral health system; (c) comprehensive statewide planning for the development of community-based behavioral health services in each behavioral health region; (d) coordination and oversight of regional behavioral health authorities, including approval of regional budgets and audits of regional behavioral health authorities; (e) development and management of data and information systems; (f) prioritization and approval of all expenditures of funds received and administered by the division, including the establishment of rates to be paid and payment processes for behavioral health services and fees to be paid by consumers of such services; (g) coordination with the Department of Health and Human Services Regulation and Licensure in the licensure and regulation of behavioral health facilities, services, professions and occupations; (h) audits of behavioral health programs and services; and (i) promotion of activities in research and education to improve the quality of behavioral health services, the recruitment and retention of behavioral health professionals, and the availability of behavioral health programs and services.

(5) The department shall adopt and promulgate rules and regulations to carry out the Nebraska Behavioral Health Services Act.

## Regional Governance

Sec. 6. (cf. 71-5002(6))

There shall be six behavioral health regions, consisting of the following counties:

(1) Region 1 shall consist of Sioux, Dawes, Box Butte, Sheridan, Scotts Bluff, Morrill, Garden, Banner, Kimball, Cheyenne, and Deuel counties;

(2) Region 2 shall consist of Grant, Hooker, Thomas, Arthur, McPherson, Logan, Keith, Lincoln, Perkins, Chase, Hayes, Frontier, Dawson, Gosper, Dundy, Hitchcock, and Red Willow counties;

(3) Region 3 shall consist of Blaine, Loup, Garfield, Wheeler, Custer, Valley, Greeley, Sherman, Howard, Buffalo, Hall, Phelps, Kearney, Adams, Clay, Furnas, Harlan, Hamilton, Merrick, Franklin, Webster, and Nuckolls counties;

(4) Region 4 shall consist of Cherry, Keya Paha, Boyd, Brown, Rock, Holt, Knox, Cedar, Dixon, Dakota, Thurston, Wayne, Pierce, Antelope, Boone, Nance, Madison, Stanton, Cuming, Burt, Colfax, and Platte counties;

(5) Region 5 shall consist of Polk, Butler, Saunders, Seward, Lancaster, Otoe, Fillmore, Saline, Thayer, Jefferson, Gage, Johnson, Nemaha, Pawnee, York, and Richardson counties; and

(6) Region 6 shall consist of Dodge, Washington, Douglas, Sarpy, and Cass counties.

Sec. 7. (cf. 71-5004 et seq.) (1) A regional behavioral health authority shall be established in each behavioral health region by counties acting under provisions of the Interlocal Cooperation Act. Each regional behavioral health authority shall be governed by a board consisting of one county board member from each county in the region. Board members

shall be appointed for staggered terms of three years and shall serve until their successors are appointed and qualified. Board members shall serve without compensation, but shall be reimbursed for their actual and necessary expenses as provided in sections 81-1174 to 81-1177.

(2) The regional governing board shall appoint a regional administrator who shall be responsible for the administration and management of the regional behavioral health authority. The regional behavioral health authority shall encourage and facilitate the involvement of consumers in all aspects of service planning and delivery within the region and shall coordinate such activities with the office of consumer affairs within the division. A regional behavioral health authority may establish and utilize such task forces, subcommittees, or other committees as it deems necessary and appropriate to carry out its duties under this section.

(3) Each regional behavioral health authority shall direct the administration and coordination of the public behavioral health system within the behavioral health region pursuant to rules and regulations adopted and promulgated by the department, including but not limited to: (a) administration and management of the regional behavioral health authority; (b) integration and coordination of the public behavioral health system within the behavioral health region; (c) comprehensive planning for the development of community-based behavioral health services within the region; (d) submission of an annual budget and a proposed plan for the funding and administration of behavioral health services for approval by the division; (e) submission of annual reports and other reports as required by the division; (f) initiation of contracts with private behavioral health service agencies and professionals for the provision of behavioral health services; (g) coordination with the division in conducting audits of behavioral health programs and services.

(4) Each county in a behavioral health region shall contribute financial support for the operation of the behavioral health authority in the region pursuant to a formula established by the department in rules and regulations. Such formula shall require contribution by counties in an amount equal to one dollar for every three dollars of General Funds. At least forty percent of such amount shall consist of local and county tax revenues and such amount shall be at least equal to that contributed by such counties in fiscal year 2002-2003. Any General Funds transferred from regional centers for the provision of community-based behavioral health services after the effective date of this act shall not be considered in determining such amount under this section.

(5) No regional behavioral health authority shall provide behavioral health services funded in whole or in part with funds received and administered by the division under the Nebraska Behavioral Health Services Act unless: (a) there are no qualified and willing providers to provide such services; (b) the regional behavioral health authority receives written authorization from the administrator to provide such services and enters into a contract with the division to provide such services; and (c) the regional behavioral health authority complies with all applicable rules and regulations adopted and promulgated by the department relating to the provision of such services by such authority, including but not limited to rules and regulations establishing definitions of conflicts of interest for regional behavioral health authorities and procedures in case such conflicts arise.

## Community-Based Services and Regional Centers

Sec. 8. (1) The division shall promote and coordinate the development and ongoing provision of an appropriate array of community-based behavioral health services and continuum of care in each behavioral health region, with the purpose of protecting the public safety and reducing the necessity and demand for acute and secure regional center services.

(2) Except as otherwise provided in this section, the division shall cease operation of the Norfolk Regional Center on or before June 30, 2005, and shall cease operation of the Hastings Regional Center on or before December 31, 2005. No regional center shall cease operation unless appropriate community-based services or other regional center services are available for every person receiving services at such regional center and no further admissions or readmissions to such regional center are required due to the availability of such services.

(3) The division shall develop, on or before July 1, 2004, a comprehensive and detailed plan to: (a) identify persons currently receiving regional center services for whom community-based services would be appropriate; (b) fund the development and ongoing provision of community-based services for such persons in each behavioral health region; (c) transition such persons from regional centers to appropriate community-based services; (d) reduce new admissions and readmissions to regional centers; and (e) provide for the public safety. Such plan shall be included as part of the behavioral health implementation plan required under section 12 of this act.

## Funding

Sec. 9. (1) The division shall coordinate the management of all funds appropriated by the Legislature or otherwise received by the Nebraska Health and Human Services System from any other public or private source and designated by the Policy Cabinet for the provision of behavioral health services.

(2) Such funds shall be efficiently and effectively integrated and managed in the best interests of consumers of behavioral health services, to ensure: (a) the availability of an appropriate array of community-based behavioral health services for consumers in each behavioral health region; and (b) the appropriate allocation of such funds in a manner consistent with the consumer's needs and plan of treatment;

## Advocacy

Sec. 10. [Combine the State Mental Health Planning and Evaluation Council, the State Alcoholism and Drug Abuse Advisory Committee, and the Nebraska Advisory Commission on Compulsive Gambling into one statewide advocacy and advisory organization that meets federal requirements, with three subcommittees. Retain provisions relating to the Compulsive Gamblers Assistance Fund.]

## Transition/Legislative Oversight

Sec. 11. (1) The Behavioral Health Oversight Commission of the Legislature is established. The commission shall consist of no more than fifteen persons appointed by the chairperson of the Health and Human Services Committee of the Legislature and confirmed by a majority vote of members of the committee. Members of the commission shall possess a demonstrated interest and commitment and specialized knowledge and expertise relating to the provision of behavioral health services in the State of Nebraska and shall be broadly representative of all behavioral health regions. Members shall be reimbursed from the Nebraska Health Care Cash Fund for their actual and necessary expenses as provided in sections 81-1174 to 81-1177.

(2) The commission, under the direction of the Health and Human Services Committee of the Legislature, shall oversee and support implementation of the plan submitted by the division under section 12 of this act and shall administer such funds as appropriated by the Legislature from the Nebraska Health Care Cash Fund and approved by the committee.

(3) The commission and this section shall terminate on December 31, 2006.

Sec. 12. The division shall submit a behavioral health implementation plan to the Governor and the Legislature on or before July 1, 2004. The plan shall be consistent with provisions of the Nebraska Behavioral Health Services Act, and shall provide a detailed description of completed and proposed activities and outcomes by the division over a three-year period to implement the act. The plan shall be reviewed by the Health and Human Services Committee of the Legislature and by the Behavioral Health Oversight Commission of the Legislature established under section 11 of this act. The division shall immediately advise the committee and the commission of any changes to the plan, and shall report at least monthly to the committee and the commission as to its implementation.

## SECTION THREE:
## ADULTS- ACCOMPLISHMENTS

- **A summary of areas in the prior Fiscal Year approved plan as needing improvement;**

**FY2003 ADULT CRITICAL GAP**

From FY2003 Community Mental Health Block Grant
CRITICAL GAPS / UNMET NEEDS

**GAP: THE DISCREPANCY BETWEEN PREVALENCE OF MENTAL ILLNESS AND NUMBER OF INDIVIDUALS SERVED BY SYSTEM.**
UPDATE – November 2003.

Funding was increased in FY2001. In 2002 and 2003, budgets using state general funds have been cut. However, at this point, the aid budget for community mental health has not been cut. At this point, the goal is to maintain services at the current levels. This was reported as a gap in the FY2004 application as GAP #1: THE DISCREPANCY BETWEEN PREVALENCE OF MENTAL ILLNESS AND NUMBER OF INDIVIDUALS SERVED BY SYSTEM.

**GAP: LACK OF ADEQUATE "STEP DOWN" SERVICES**
UPDATE – November 2003.

This is looking at the flow of adults through the Nebraska Behavioral Health System (NBHS). Several projects are underway to address this issue.

LB 724 is designed to implement changes to NBHS.

The Mental Health Housing Planner Contract with HANNA:KEELAN ASSOCIATES, P.C. has completed Project #1 – Nebraska, Statewide Consumer Housing Need Study (September 2003). See the HHSS web site for the complete report
<http://www.hhs.state.ne.us/beh/Housesum.htm>

- The Target Population is people who are 19+ years of age, and low- to extremely low income, with serious mental illness. This Population is non-institutionalized, non-hospitalized, either (1) homeless or
- (2) residing in a household, experiencing housing cost burden and/or housing problems.

- Low Income – 50% Area Median Income (AMI) equals an estimated 140% poverty level
- Extremely Low Income – 30% AMI equals close to 100% poverty level

- Housing Cost Burden - tenants paying over 30 percent of their gross income for housing. An annual income of 0 to 30 percent AMI will experience a housing cost burden (pay 30% or more of their income for rent or a home payment, and utilities). A common remedy for Cost Burden is to provide persons/families with Rental Assistance, whereas the tenant only pays 30% of their income for rent and utilities.

- Housing Problems - as per the definition of the U.S. Department of Housing and Urban Development: lacking complete plumbing (inadequate plumbing, kitchen or bathroom fixtures/appliances) and/or 1.01+ persons per room (overcrowded conditions). Housing

Problems often result in substandard housing conditions. Various Federal and State programs provide funding for housing rehabilitation to improve the condition of substandard housing.

- By 2008, the Target Population will equal an estimated 12,763; 2,698 @ 19-21 years @ < 50% AMI, 10,065 @ 22+ years @ < 30% AMI. Target Household Need, by 2008, equals 3,926, or 31% of the Target Population.

This was reported as a gap in the FY2004 application as GAP #3: LACK OF ADEQUATE "STEP DOWN" SERVICES.

**GAP: INFORMATION SYSTEM IS INADEQUATE**
UPDATE – November 2003.

In the FY2004 application, this gap was still reported as GAP #4: INFORMATION SYSTEM IS INADEQUATE.

As part of the work to improve the quality of the community mental health data, Magellan Behavioral Health moved the Nebraska data to a new server. Now the Nebraska Behavioral Health System data and Nebraska Medicaid data under the Magellan Behavioral Health contract are on the same platform. This new capacity became operational on October 22, 2003. The move included some update data collection requirements such as requiring all fields to be mandatory.

There is a need to work on improving the management information systems used by the Office of Mental Health, Substance Abuse and Addiction Services. The long term goal is to develop a single management information system to cover Community-based Mental Health, Substance Abuse, and the Regional Centers (Hastings Regional Center, Lincoln Regional Center, Norfolk Regional Center). This includes improving provider participation in the information system. Such efforts are expected to result in improving the quality of data in the NBHS Management Information System. This also includes the need to improve the capacity to measure service capacity. This improved ability would be useful in managing the system as well as tracking gaps in services. It would also help in establishing performance measures. Under the current operations, it is very difficult to measure outcomes in relationship to funds expended.

In general, the data will be used to answer questions such as "who are we serving?" "What services are they getting?" and "What results were produced?".

HHS is using three strategies to address this issue:
1. Include the need for this within the LB724 proposals
2. Upgrade AIMS to AVATAR in the Regional Centers
3. Nebraska Mental Health Data Infrastructure Grant

"Advanced Institutional Management Systems" (AIMS) is the data system used by the three State of Nebraska Psychiatric Hospitals (Hastings Regional Center, Lincoln Regional Center, Norfolk Regional Center). Plans are underway to upgrade to the Creative Socio-Medics (CSM) Corporation software called "AVATAR".

Under the Nebraska Mental Health Data Infrastructure Grant work is being done to improve the capacity to report the data. This capacity should be ready for the FY2004 Implementation Report.

**GAP: SHORTAGE OF CREDENTIAL & ADMINISTRATIVE STAFF**
UPDATE – November 2003.

In the FY2004 application, this gap was still reported as GAP #5: SHORTAGE OF CREDENTIALED & ADMINISTRATIVE STAFF. There is a critical shortage of qualified Nebraska Behavioral Health Staff for providing treatment, rehabilitation and support services as well as handling administrative functions. The shortage of credential staff includes psychiatrists, psychologists, licensed mental health practitioners (LMHP), nurses and Certified Alcohol/Drug Abuse Counselors (CADAC). With all the increasing expectations on what the Nebraska Behavioral Health System (NBHS) needs to address, there also needs to be adequate supply of administrative personnel at all levels of operations.

**GAP: MEDICATION ACCESS**
UPDATE – November 2003.

In the FY2004 application, this gap was still reported as GAP #6: MEDICATION ACCESS. This gap involves many things related to providing access to psychiatric medications for persons with serious mental illness or youth with severe emotional disturbance.

The following information was included in housing study prepared under the Mental Health Housing Planner Contract with HANNA:KEELAN ASSOCIATES, P.C. has completed Project #1 – Nebraska, Statewide Consumer Housing Need Study (September 2003). See the complete report at http://www.hhs.state.ne.us/beh/Housesum.htm.

Below is a Medicaid report covering calendar year 2001 (the most complete year).

Costs for Medicaid Eligibles with Serious Mental Illness (SMI) by Age Group, Calendar Year 2001 ("Medicaid SMI Report" July 23, 2003)

| Age Group[1] | Medicaid Eligibles with SMI (Eligibility Years)[2] | Costs | | | | |
|---|---|---|---|---|---|---|
| | | SMI Outpatient[3] | Other Outpatient[3] | Total Outpatient[3] | All Drugs[4] | Total |
| 19-21 | 491 | $211,520 | $540,678 | $752,198 | $961,683 | $1,713,881 |
| 22+ | 9,829 | $5,882,331 | $8,834,716 | $14,717,047 | $42,706,791 | $57,423,838 |
| Total | 10,320 | $6,093,851 | $9,375,394 | $15,469,245 | $43,668,474 | $59,137,719 |

| Age Group[1] | Medicaid Eligibles with SMI (Eligibility Years)[2] | Costs per Eligibility Year with SMI | | | | |
|---|---|---|---|---|---|---|
| | | SMI Outpatient[3] | Other Outpatient[3] | Total Outpatient[3] | All Drugs[4] | Total |
| 19-21 | 491 | $431 | $1,101 | $1,532 | $1,959 | $3,491 |
| 22+ | 9,829 | $598 | $899 | $1,497 | $4,345 | $5,842 |
| Total | 10,320 | $591 | $909 | $1,499 | $4,232 | $5,731 |

1. Age at time of first outpatient visit (after 19th birthday) in CY 2001
2. A Medicaid Eligible was said to have SMI if he/she was at least 19 years of age and had a primary or secondary diagnosis of 295-298.9 in an outpatient setting during CY 2001

3. Costs incurred at crisis/respite care, group residential, and residential facilities are excluded
4. Cost of all prescription drugs (not only psychiatric medications)

Please note:

- the drug costs are not broken down into "psychiatric medications" and "others". The report calculates the costs for all drugs prescribed for eligibles with SMI.

the total cost (for both outpatient services and drugs) for one person with SMI in Medicaid for one year (2001) was $5,730.

**GAP: CULTURALLY COMPETENT SERVICES**

UPDATE – November 2003.

In the FY2004 application, this gap was still reported as GAP #7: CULTURALLY COMPETENT SERVICES. A critical service gap in the adult and children's mental health system appears to be cultural and linguistically competent services. A language barrier has arisen in several communities across Nebraska, rural and urban, due to the increase in minority populations living across the state. There is lack of access to bi-lingual mental health professionals and family support services. Services which recognize the unique cultural needs of all Nebraskans are not always available. This lack of access should be recognized and culturally competent services should be developed. The new immigrant/refugee populations in Nebraska also needs to be addressed.

**GAP: DEVELOPMENTALLY APPROPRIATE SERVICES FOR YOUTH IN TRANSITION**

UPDATE – November 2003.

There remains many challenges in this area. One strategy to address these problems involved the Mental Health Housing Planner Contract with HANNA:KEELAN ASSOCIATES, P.C. Within Project #1 – Nebraska, Statewide Consumer Housing Need Study (September 2003), the target population included people who are 19+ years of age, and low- to extremely low income, with serious mental illness. See the HHSS web site for the complete report

<http://www.hhs.state.ne.us/beh/Housesum.htm>

## ACCOMPLISHMENTS – A BRIEF NARRATIVE – 2003 ADULT GOALS

For FY2003, Nebraska had three (3) goals for Adults:

FY2003 GOALS FOR ADULTS

Goal 1: STRATEGIC PLANNING - Implement Strategic Planning to Improve the Quality and Delivery of Services provided by the Nebraska Behavioral Health System.

Goal 2: EMPOWER CONSUMERS - Continue Development of the HHS Consumer Liaisons as State Leaders to help empower consumers to work as Change Agents and Advocates.

Goal 3: SUICIDE PREVENTION INITIATIVE - Continue Development of Statewide Suicide Prevention Initiative

### ADULT GOAL #1: STRATEGIC PLANNING

**Implement Strategic Planning to Improve the Quality and Delivery of Services provided by the Nebraska Behavioral Health System.**

**ACHIEVED**

Consistent with the Governor's priority on mental health and LB 724, implement Strategic Planning to Improve the Quality and Delivery of Services provided by the Nebraska Behavioral Health System.

Work on implementation of the MH Data Infrastructure Grant to address the data issues …

HOUSING

The Statewide Mental Health Housing Coalition was formed between the Nebraska Department of Health and Human Services (HHS) Office of Mental Health, Substance Abuse and Addiction Services and the Nebraska Department of Economic Development (DED) Community and Rural Development Division. Both HHS and DED are committed to the development of housing that is affordable, decent, safe, and appropriate for people who are extremely low income with serious mental illness.

The long-term goal of this Housing Coalition is to improve the availability of housing for people who are extremely low income with serious mental illness. These mental health housing plans are expected to help address Governor Mike Johanns' expectations to:

1. Decrease the number of post commitment days
2. Decrease the number of Emergency Protective Custody (EPC) situations
3. Decrease the number of days consumers are served in inappropriate levels of care

The HHS and DED co-sponsored the "Nebraska Mental Health Housing Coalition Planning Meeting" held on January 29, 2002.

On May 1, 2002, HHS and DED released the "Mental Health Housing Planner Request For Proposals". Five bids were officially received on June 12, 2002. All five were formally reviewed. As a result of that review, the bid selected was submitted by HANNA:KEELAN ASSOCIATES, P.C., Lincoln, NE (Project #1 $68,500; Project #2 $54,200; TOTAL $122,700)

The HHS and HANNA:KEELAN ASSOCIATES, P.C. have signed the contract to implement these projects. Ron Ross, Director of the Nebraska Department of Health and Human Services, signed the contract on November 27, 2002. The total contract is for $122,700. The funding sources for the contract are:

- $10,000 from the Federal Center for Mental Health Services State Coalition Building funds for this contract.
- $112,700 of HOME (federal) funds through the Nebraska Department of Economic Development, Community and Rural Development Division.

The contract with Hanna:Keelan Associates, P.C., Lincoln, NE is to complete planning to focus on people who are extremely low income with serious mental illness needing housing. There are two projects covered in the contract:

- Project #1 statewide consumer housing need study (draft July 24, 2003) and
- Project #2- planning in four communities Omaha, Lincoln, the Norfolk Area & Tri-City Area (Hastings, Grand Island, and Kearney) (in process).

MENTAL HEALTH HOUSING PLANNING STEERING COMMITTEE - Purpose Of Committee: Develop by December 2003, plans that will focus on people who are extremely low income with serious mental illness needing housing. To accomplish this, the Steering Committee:

- participates in the mental health housing planning work performed by Hanna:Keelan Associates and
- provide their assessment on the overall housing needs for persons who are extremely low income with serious mental illness statewide based on their participation in the study.

Membership of the Mental Health Housing Planning Steering Committee includes: HHS State Long-Term Care Ombudsman, Department of Economic Development, U.S. Department of Housing and Urban Development (HUD), Nebraska Investment Finance Authority, Regional Governing Boards, Mental Health Associations of Nebraska, National Alliance for the Mentally Ill – Nebraska (NAMI-NE) and members of the Nebraska Mental Health Planning and Evaluation Council.

STATEWIDE HOUSING MEETING - HHS is sponsoring the Nebraska Mental Health Housing Summit on November 19, 2003. HHS will sponsor this statewide mental health housing meeting to publicly share the findings from Projects #1 and #2. The funds for this meeting are from the Federal Center for Mental Health Services State Coalition Building (Olmstead) grant.

EMPLOYMENT

As noted in SECTION III. A. Fiscal Planning Assumptions for Adults and Children the State community mental funds are used to match federal funds from Department of Education Division of Vocational Rehabilitation through a State Cooperative Agreement. Approximately $1.6 million is devoted to these employment services yearly using a 21% State to 79% federal match rate to serve persons with mental illness in vocational rehabilitation services.

For the last few years, employment issues for individuals with a serious mental illness were being addressed under a project called "EMPLOYMENT 2003". In June 2001, Nebraska officially expanded the "Coalition to Promote Community Based Care Under Olmstead" proposal to include housing, employment, and related issues. George Hanigan, HHS Deputy Director for Behavioral Health (SMHA Commissioner) requested this expansion. The coalition structure Nebraska used was flexible in order to include stakeholders as appropriate for the issues being addressed.

On November 13, 2001, the Employment 2003 Steering Committee submitted to the State Mental Health Planning and Evaluation Council (MHPEC) a report of recommendations for increasing employment opportunities for people with mental illness. The report was also submitted to state vocational rehabilitation, state mental health, and other key stakeholders.

One of the recommendations for enhancing employment opportunities for people with mental illness involved providing opportunities to help local providers network in a forum focused on these issues. The funds for these forums were from the Federal Center for Mental Health Services State Coalition Building (Olmstead) grant.

The agenda for the employment forums included discussions on vocational rehabilitation, social security, benefits analysis, successful employment opportunities, and related topics. Two employment forums were held:
-- The Kearney Employment Forum was held on October 8, 2002. 43 people attended.
-- The Omaha Employment Forum was held on February 28, 2003. 65 people attended.

In March 2003, the HHS staff member working on these employment issues resigned to take another position. As a result, it was appropriate to take some time to discuss the next steps on this project. That discussion was held at the June 12, 2003 Mental Health Planning and Evaluation Council meeting. After the discussion, a motion that was passed (vote 19 Yes / 0 No) which said:

> "The MHPEC asked Ron Ross to support and approve a permanent sub-committee that would play a pivotal role in helping to plan, implement, monitor, and advocate for effective employment services for individuals with psychiatric disabilities."

It was approached in this manner because Nebraska Statute for the Nebraska Mental Health Planning and Evaluation Council [§71-5008.(4)] requirements include the following statement:

> "Upon receiving the written approval of the Director of Health and Human Services, the chairperson may appoint and utilize a task force of council members and nonmembers to report to the council on specific areas."

At the same meeting, it was discussed that additional employment forums should be held. HHS and VR will explore ways to hold additional employment forums. At the time of this writing, plans are being discussed to hold two additional, starting with Norfolk, NE.

**FY2003 ADULT GOAL #2: EMPOWER CONSUMERS**
**Adult Goal #2: Continue Development of the HHS Consumer Liaisons as State Leaders to help empower consumers to work As Change Agents and Advocates.**
**ACHIEVED**

The Office of Mental Health, Substance Abuse and Addiction Services has two full-time Consumer Liaisons on staff, Dan Powers and Phyllis McCaul. Overall, the consumer liaisons continue working as change agents and advocates as staff members within the Office of Mental Health, Substance Abuse and Addiction Services. Their leadership both within the Office and in community settings changes the dynamics of a meeting, with consumer concerns being addressed more consistently.

FUNDING:
The Office of Mental Health, Substance Abuse and Addiction Services allocates **$337,604** annually on consumer empowerment oriented activities. In FY2003, this includes:

- The primary funding source for the consumer liaisons is the five percent (5%) state administrative portion of the Community Mental Health Services (CMHS) Block Grant. In FY2003, this allocation is **$102,104**.

- State Consumer Initiatives

(1) National Alliance for the Mentally Ill –Nebraska (**$45,750**): The Office contracts with the National Alliance for the Mentally Ill -Nebraska to ensure a state organizational structure is available for consumers. This contract provides support for the development of infrastructure for mental health education, support and advocacy.
(2) League of Human Dignity (**$10,000**): This contract is used to fund cash advances and reimbursements to consumers in order to help people attend meetings, workgroups and conferences.
(3) Mental Health Association of Nebraska(**$45,750**). The Office plans to contract with the Mental Health Association to train nursing home and assisted living staff in each region on how to work with persons with mental illness and behavior problems. A specific curriculum has yet to be developed

- Peer Specialists
  With the FY2000 Federal Community Mental Health Block Grant increase, the Office started funding two (2) Peer Specialist positions (**$60,000**) in Day Support.

WEB SITE: The Nebraska Department of Health and Human Services web site provides a summary on how to contact the Consumer Liaisons. Go to the HHS web site and click on "Behavioral Health". http://www.hhs.state.ne.us/beh/behindex.htm
- Click on: Citizen Advocacy and Planning Groups
- Click on: Mental Health Consumer Advocacy
- You will arrive at <http://www.hhs.state.ne.us/beh/mh/mhadvo.htm>

On the "Mental Health Consumer Advocacy" web site there are links to national and state mental health advocacy groups:
- National Alliance for the Mentally Ill
- National Alliance for the Mentally Ill – Nebraska
- National Mental Health Association

Mental Health Association of Nebraska

AREAS OF WORK
There are a number of areas the two Consumer Liaisons address, including:

- Mental Health Consumer Advocacy

Those individuals who are experiencing difficulty with Nebraska's mental health system are encouraged to contact either Dan Powers or Phyllis McCaul (call 1-800-836-7660 or e-mail).

- Annual Consumer Conference

Annually the Office funds a consumer conference designed to educate consumers in mental health issues and to speak up to national, state and local mental health officials to advocate on their and the systems behalf. The consumer liaisons facilitate the planning and implementation for the Consumer Conference. This year the 2003 Mental Health Consumer Conference was held on September 23-25, 2003 in Aurora, NE. Mary Ellen Copeland was the featured speaker. The Governor Mike Johanns made a brief presentation of his plans for reform of the Mental Health System in Nebraska. (The Governor has identified Mental Health as his number one priority this year.) Information is posted on the Behavioral Health Web site.

The consumers participating in this annual conference come from all across the state. In order to participate, a consumer completes an application form and sends it to HHS. As there were 199 people who submitted an application. The order of selection is: (1) those who have not attended the conference before, (2) represent a minority or ethnically diverse group, (3) least number of times attending a conference with consideration for geographic distribution.
(4) willingness to attend and participate in conference based on information in application. Due to the budget constraints, the conference participants were limited to 100 persons.

Included in the 100 participants are "Conference Guides". These consumers are expected to serve in a leadership role during this annual conference. In order to be considered for this role, the individual needs to have (1) attended the conference before, and (2) received leadership training.

The "Conference Guides" duties include a number of different roles. One role is to help participants find their way around the conference. For example, helping a first time participant to decide which event to attend.

A second function is to serve as a role model in sharing the results from this conference with other consumers. Here, some of the Conference Guides serve a group facilitators. Conference participants are divided into groups of about 10-20 participants. Within each group, participants have the opportunity to share ideas and thoughts on what has been learned during the conference. A group spokesperson, other than the Conference Guide, gave a report to the all conference participants on the last day. This was followed by an open microphone where consumer participants expressed anything they wanted to the group.

- Advisors on HHS Community Mental Health Policy

The consumer liaisons routinely participate in HHS Community Mental Health policy development. Examples include:
(1) Attend the monthly Network Management Team meetings.
(2) Attend the NMT/CEO Transition Training Planning Team.
(3) Advise the Legislature on the amendment of Mental Health Commitment Statutes and changes in the mental health system

The monthly Network Management Team meeting is important to the delivery of services to consumers. At the Network Management meeting HHS staff and Regional Program Administrators discuss implementation of contracts for the delivery of services and other issues including planning for long term goals.

- Peer Specialists

With the FY2000 Federal Community Mental Health Block Grant increase, the Office started funding two (2) Peer Specialist positions ($60,000) in Day Support. The two Peer Specialist positions funded were:

✓ Cirrus House, Scottsbluff (Region 1)
✓ Central Nebraska Goodwill, Grand Island (Region 3)

The term "Peer Specialist" was defined as "a person who is a consumer with a history of meeting the SMI criteria, however, has been in recovery to the point of being able to hold down a job, lives independently, and other related signs of functional stability."

- Consumer/Survivor Mental Health Administrators

Participate in activities and meetings with the National Association of Consumer/Survivor Mental Health Administrators. One of the consumer liaisons is President of the National Association of Consumer Survivor Mental Health Administrators and was involved in preparation of "A Roadmap to a Restraint Free Environment for Persons of All Ages". Plans are being made to pilot this manual in two facilities. As President of NAC/SMHA he attended the National Association of Mental Health Program Directors Winter Meeting in Fort Lauderdale and the Summer Meeting in San Diego. At the Summer Meeting he was given the Commissioner's proxy and represented the State of Nebraska also. The Association held a Retreat in Boston in October 2002 and held a training in St. Louis in September 2003. As President he was invited to attend a block grant peer review as an observer to the southeastern region peer review in Arlington, Virginia November 29-21, 2002 and the Southwestern States peer review in Jackson, Wyoming October 28-30, 2003 As President he was invited to comment at the National Call to Action: Elimination of Restraint and Seclusion held May 5, 2003 in Washington DC. He strongly supported the elimination of Restraint and Seclusion and thanked Charles Curie for his leadership in this area.

- Co-Coordinate the annual Board of Mental Health Training

One of the Consumer Liaison co-coordinates the training of the Boards of Mental Health. This Mental Health Board Training is a requirement of the Mental Health Commitment Act [Neb. Rev. Stat. § 83-1018 (4)]. For more information on this work, see Criteria 5.

- Substance Abuse Consumers

A new initiative is the development of Substance Abuse Consumers to be advocates. The consumer liaisons are working with several substance abuse providers on establishing the Nebraska Recovery Network. The purpose of this network is (1) to provide the recovering community and its allies with a public voice to communicate their unique perspective and (2) to provide insight about the disease of addiction and the road to recovery." It is planned to use $14,000 of State Substance Abuse funds to help build the Nebraska Recovery Network.

- Consumer Satisfaction Program Visits

The consumer liaisons complete "Consumer Satisfaction Program Visits" to programs throughout the State. A Consumer Liaison does four or more community program site visits monthly. Each

program visit results in a report given to HHS staff, Regional Program Administrator for that area, and the director of the program. The report covers the consumer liaison's observations and opinions; as well as the aggregated results from the question survey with consumers. The question in this survey are usually handled in a face-to-face interview. Usually 5 face-to-face surveys are completed. Some locations distribute the questions in a written form for consumers to complete.

Phyllis McCaul, Consumer Liaison, revised (as of August 5, 2003) the questions for Consumers Satisfaction Visits. It starts with noting the Name of Program / Date / Type of Program. Then she asks the questions listed below:

Group 1: Access to Health Care

Doctor

a. Do you have a physical health care doctor? Yes or No
b. If no then why?
c. Do you know the name of your doctor? Yes or No
d. When was the last time you visited him/her?
e. Did the program help you find your doctor? Yes or No

Dentist

a. Do you have a Dentist? Yes or No
b. If no then why?
c. Do you know the name of your dentist? Yes or No
d. When was the last time you visited him/her?
e. Did the program help you find your dentist? Yes or No

Vision

a. Have you had your vision checked? Yes or No
b. If no, then why?
c. When was the last time you had your vision checked?
d. Where did you go to do this?
e. Did the program help you fine this place? Yes or No

Psychiatrist

a. Do you have a psychiatrist? Yes or No
b. If no, then why?
c. Do you know the name of your psychiatrist? Yes or No
d. When was the last time you visited him/her?
e. Did the program help you find your psychiatrist? Yes or No

Group 2.

1. a. Would you rate this program as: Excellent, Good, Fair, Poor, Don't know
   b. Why do you feel this way?
2. What are your plans for the future?
3. Do you feel that the staffs at this program respect you?
4. What do you think would help you in this program?
5. How long have you been in this program?
6. a. Were you involved in developing your rehab goals?
   b. If so, was your input taken into consideration and did it become part of the goals.
7. Are you making progress to complete your goals?
8. a. How often are your rehab goals updated?
   b. Are your ideas put into those goals?

Other Comments:

- Consumer Mailing List

The liaisons have developed and maintained a list of interested people to receive mailings on consumer oriented topics. This list is also used as a source of information on individuals who may be interested in working on state or regional advisory or strategic planning groups. Most of the names on this mailing list are collected during the Consumer Satisfaction Program Visits'.

- Liaison to the Mental Health Association

The Mental Health Association – Nebraska reaches a lot of consumers. One project will involve one of the consumer liaisons to work in coordination with the HHS State Long-Term Care Ombudsman and Mental Health Association to make quality changes in all of the Assisted Living Facilities (ALF) licensed in Nebraska who are serving residents who are mentally ill.

- Homelessness. Dan Powers has been assigned as Program Director of PATH grant and plans to make a special effort aimed at reducing homelessness of person with mental illness.

**ADULT GOAL #3: SUICIDE PREVENTION INITIATIVE**

**Adult Goal #3: Continue Development of Statewide Suicide Prevention Initiative**

**ACHIEVED**

The Suicide Prevention Curriculum was developed by the Southeast Nebraska Suicide Prevention Project through a grant from the Nebraska Health Care Cash Fund – a program of the Nebraska Health & Human Services System. This material was created to educate the public and key helpers about suicide and its prevention. All materials may be reproduced with credit given to the Southeast Nebraska Suicide Prevention Project.

Members of the Statewide Suicide Prevention Initiative committee worked in collaboration to submit a grant to Nebraska Health Care Council (overseeing the tobacco money in HHS). The Nebraska Health Care Cash Fund Grant award was for a total of $125,000.

- Year one started October 1, 2001 and is for $75,000.
- Year two ended September 30, 2003 and is for $50,000.

Blue Valley Mental Health Center in Beatrice NE is the grant recipient, in collaboration with the Community Mental Health Center of Lancaster County (CMHC) and BryanLGH Medical Center in Lincoln.

Overall, the grant was intended to help develop local expertise in suicide Prevention. Curricula was developed in year one and tested in year two. The final product was a public domain curriculum in suicide prevention designed for delivery via a train the trainers model. This model develops and maintains local expertise in suicide prevention. The curriculum will soon be made available for download from a web site.

The target population for this pilot was adults in Southeast Nebraska with emphasis on reaching those at highest risk for suicide. The major goals of the project include:

1. Increase awareness of warning signs, risk factors, and interventions to prevent suicide.
2. Reduce stigma surrounding suicide and seeking help.
3. Positively influence a reduction of the suicide rate in southeast Nebraska.

Here is a brief summary of suicide prevention activities as of July 28, 2003.

- The Nebraska State Suicide Prevention Work Group has met quarterly. This is an open group with a core membership. It is unfounded but includes representatives from government, Universities, Corrections, Survivors, Law Enforcement, Human Service Agencies, and Faith-based groups.
- The state work to date was presented at the American Association of Suicidology in April, 2002 and April, 2003.
- An update on the state suicide prevention activities was given at the Mental Health Planning & Evaluation Council meeting on June 12, 2003
- The core curriculum and the four specialty modules have been developed and tested. The four specialized areas are:
    - **Law Enforcement** – this module has been adopted by the State Law Enforcement Training Academy in Grand Island and the Police Department in Lincoln, Nebraska as official curriculum for recruit training.
    - **Primary Care Providers** – The core curriculum and healthcare module has been made into a video for distribution and use by BryanLGH Medical Center in Lincoln and within the Heartland Health Alliance (a consortium of Hospitals throughout Southeast Nebraska.) BryanLGH has made the curriculum part of required training for medical center staff on both campuses in the city.
    - **Educators** – This module has been introduced to educators in several Southeast Nebraska communities as well as the School and Community Substance Abuse Intervention Teams.
    - **Faith-Based Workers** – Clergy and faith-based workers around Southeast Nebraska have participated in both the core training and the specialized faith based module. This module has been used to pilot eulogy recommendations for the Suicide Prevention Resource Center that serves as a national technical assistance provider to states in the area of suicide prevention planning and implementation.

What's next?

1. Year two funding for the Southeast Suicide Prevention Project ended September 30, 2003. They are seeking funding to evaluate the effectiveness of this gatekeeper training.
2. The State Suicide Prevention Work Group will continue to support the evaluation and dissemination of gatekeeper training while working to update the Nebraska State Plan for Suicide Prevention.
3. Representatives from the State Work Group attended a multi-state planning and education conference sponsored by the Suicide Prevention Resource Center in October 2003.
4. The State Work Group will work toward furthering awareness, intervention, and methodology through networking and integration of activities with existing resources, projects, and venues as the amount of funding dedicated to suicide prevention from the state is expected to remain flat.

Suicide Prevention Curriculum is posted at the following web site:
http://www.nebhands.nebraska.edu/technicalassistance.htm#suicide

For more information about the Suicide Prevention Curriculum contact Denise Bulling (dbulling@nebraska.edu) at the University of Nebraska Public Policy Center.

**ADULTS WITH SERIOUS MENTAL ILLNESS**

**Criterion 1**: Comprehensive Community- based Mental Health Service Systems

- Provides for the establishment and implementation of an organized community-based system of care for individuals with mental illness.
- Describes available services, and resources in a comprehensive system of care, including services for individuals diagnosed with both mental illness and substance abuse. The description of the services in the comprehensive system of care to be provided with Federal, State, and other public and private resources to enable such individuals to function outside inpatient or residential institutions to the maximum extent of their capabilities shall include:
  - Health, mental health, and rehabilitation services;
  - Employment services
  - Housing Services
  - Educational Services
  - Substance Abuse Services
  - Medical and dental services
  - Support services
  - Services provided by local school systems under the Individuals with Disabilities Education Act;
  - Case management services; and
  - Other activities leading to reduction of hospitalization.

**FY 2004 Nebraska MENTAL HEALTH PLAN**
**Criterion 1: Comprehensive Community- based Mental Health Service Systems**

**GOAL:** Maintain capacity of Community Support Services
**OBJECTIVE:** In light of current state budget, by June 30, 2003, the number of persons served with Serious Mental Illness receiving Mental Health Community Support Services will remain at current capacity (as of July 2003, there are about 2,450 slots of Community Support services).

**POPULATION: SMI Adults**

**Number of persons SMI who are receiving Mental Health Community Support (including case management) services**
Value = all persons reported SMI receiving Mental Health Community Support

| Performance Indicator (1) | **FY 2000** Actual (2) | **FY2001** Actual (3) | **FY2002** Actual (4) | **FY2003** Actual | **% Attained** |
|---|---|---|---|---|---|
| Value: | 1,983 | 2,140 | 2,607 | 2,613 | 100% |

**Number of persons SMI who are receiving Mental Health Community Support (including case management) services**
Value = all persons reported SMI receiving Mental Health Community Support

**Criterion 2:** Mental Health System Data Epidemiology

- Contains an estimate of the incidence and prevalence in the State of serious mental illness among adults and serious emotional disturbance among children; and
- Presents quantitative targets to be achieved in the implementation of the system of care described under Criterion one (1).

**FY 2004 Nebraska MENTAL HEALTH PLAN**
**PERFORMANCE INDICATORS**

**GOAL:** To maintain the number of people receiving Mental Health Services.

**OBJECTIVE:** To maintain the number of persons age 18 or older (unduplicated count) in FY2004 (no cut in program capacity).

**POPULATION:** Adults receiving mental health services within the Nebraska Behavioral Health System (NBHS)

| Magellan Behavioral Health Unduplicated Persons Served / Age 18+ | | | | | |
|---|---|---|---|---|---|
| Performance Indicator | **FY2001 Actual** | **FY2002 Actual** | **FY2003 Actual** | **FY2004 Objective** | **% Attain** |
| M H Services only | 14,816 | 15,962 | 17,328 | 17,000 | |

NOTE: the complete report includes the following information.

| | FY2001 | | FY2002 | | FY2003 | |
|---|---|---|---|---|---|---|
| | | | | | | |
| **By Services:** | 30,900 | 100.0% | 33,821 | 100.0% | 31,587 | 100.0% |
| MH only | 14,816 | 48.0% | 15,962 | 47.2% | 17,328 | 54.9% |
| SA only | 12,851 | 41.6% | 13,832 | 40.9% | 11,182 | 35.4% |
| Dual only | 33 | 0.1% | 34 | 0.1% | 426 | 1.3% |
| MH/SA | 1,156 | 3.7% | 1,391 | 4.1% | 1,723 | 5.5% |
| MH/Dual | 15 | 0.1% | 31 | 0.1% | 15 | 0.0% |
| SA/Dual | 7 | 0.0% | 9 | 0.0% | 1 | 0.0% |
| MH/SA/Dual | 15 | 0.1% | 19 | 0.1% | 1 | 0.0% |
| Unknown | 2,007 | 6.5% | 2,543 | 7.5% | 911 | 2.9% |

This chart is the number of individual adults served by type of program.

- The **Mental Health Services** (MH) include Residential Rehabilitation, ACT, Community Support-MH, Day Treatment, Day Rehabilitation, Vocational Support, Day Support, Outpatient (Individual, Family, Group), and Medication Management.
- The **Substance Abuse Services** (SA) include Short Term Residential, Therapeutic Community, Halfway House, Community Support-SA, Outpatient (Individual, Family, Group), Detox, and Methadone Maintenance.

**Criterion 4**: Targeted Services to Rural and Homeless Populations
- Describes states' outreach to and services for individuals who are homeless;
- Describes how community-based services will be provided to individuals residing in rural areas.

GOAL: With the Rural Mental Health Program, provide services to the rural residents of Nebraska impacted by the prolonged decline of the farm/rural economy in Nebraska.

OBJECTIVE: In FY2004, provide 2,500 counseling sessions to 800 people (individuals or families) under the crisis counseling vouchers program.

POPULATION: Residents of Nebraska's rural and frontier areas including farmers, ranchers, spouses, children, and others who are directly affected by the continued economic crisis.

Value: average number of sessions per individual/family
Numerator: unduplicated count / people served (individual or family)
Denominator: total number of counseling sessions

| Performance Indicator: (1) | FY2001 Actual (3) | FY 2002 Actual (4) | FY2003 Actual (5) | FY2004 Objective | % Attain |
|---|---|---|---|---|---|
| Value: | 5.73 | 4.2 | 2.4 | 2.5 | |
| Numerator | 229 | 625 | 845 | 800 | |
| Denominator | 1312 | 2625 | 2025 | 2000 | |

Discussion:
- In FY2000 and FY2001, the Rural Mental Health Hotline and Voucher Program budget was $50,000 (Hotline $20,000; Voucher program $30,000).
- In FY 2002, the Rural Mental Health Hotline and Voucher Program budget was increased to $100,000. (Hotline; $20,000; Voucher program $80,000). In FY 2003 and FY 2004, the budget remained at the same level of funding as FY 2002. In FY 2004, the $100,000 was moved to the Voucher Program.

Data source: from NE Office of Mental Health, Substance Abuse and Addiction Services

**Criterion 5:** Management Systems

- Describes financial resources, staffing and training for mental health service providers that are necessary for the implementation of the plan
- Provides for training of providers of emergency health services regarding mental health
- Describes the manner in which the State intends to expend the grant under Section 1911 for the fiscal year involved

**FY 2004 Nebraska MENTAL HEALTH PLAN**
**PERFORMANCE INDICATORS**

**Population: SMI Adults**
**Criterion 5:** Management Systems

**GOAL:** At least maintain the Per Capita State Expenditures for Community Mental Health Services

**OBJECTIVE:** By June 30, 2004, the per capita state expenditures for community mental health services will be maintained over $15.00

**POPULATION:** Total population

**Per Capita State Expenditures for Community Mental Health Services**

Numerator = FY2001 and FY2002 is "actual" Mental Health State Expenditures (as reported for the Maintenance of Effort section of the Block Grant Application)

Numerator Data source: Office of Mental Health, Substance Abuse and Addiction Services

Denominator = Total State population

Data Source: Nebraska Databook, Last Updated on 5/21/01 based on data from U. S. Bureau of the Census Web site (www.census.gov) 2001 <http://info.neded.org/stathand/bsect8.htm>

| Performance Indicator: | **FY 2002** Actual | **FY 2003** Actual | **FY2004** Objective | **% ATTAIN** |
|---|---|---|---|---|
| Value: | $14.03 | $16.97 | $17.46 | |
| Numerator | $24,015,746 | $29,036,852 | $29,874,816 | |
| Denominator | 1,711,263 | 1,711,263 | 1,711,263 | |

**SECTION FOUR:**
**CHILDREN – ACCOMPLISHMENTS**

**A Summary of Areas Needing Improvement in FY03 Plan**

The identification of critical gaps in service delivery and unmet needs was derived from five sources. These sources included: 1) planning meeting held by the Office of Mental Health, Substance Abuse and Addiction Services staff 2) Needs assessments (LB433 reports) submitted by the six regional youth specialists, 3) the Governor's Symposium for Early Child Mental Health, 4) the Nebraska Family Portrait Planning Process, and 5) a discussion of unmet needs with the Mental Health Planning and Evaluation Council. The needs identified by each of these processes varied, but centered on 5 basic areas. The areas are described below.

LACK OF MIDDLE INTENSITY SERVICES FOR YOUTH

Although many services are available throughout Nebraska, generally they are not available in sufficient quantities to meet the behavioral health needs of Nebraska's youth. Each region used a variety of methods to determine service gaps and priority needs including strategic planning meetings, focus groups with providers, consumers, and other child-serving agencies, surveys, analysis of system trends, review of the research on service effectiveness, and analysis of population and need data.

CULTURALLY COMPETENT SERVICES

A critical service gap in children's mental health system appears to be cultural and linguistically competent services for children and their families. A language barrier has arisen in several communities across Nebraska, rural and urban, due to the increase in minority populations living across the state. There is lack of access to bi-lingual mental health professionals and family support services. Services which recognize the unique cultural needs of all Nebraskans are not always available. This lack of access should be recognized and culturally competent services should be developed.

FALLING THROUGH THE CRACKS: CHILDREN OUTSIDE OF TARGET POPULATION ACCESSING SERVICES

Currently, services in the public system are primarily available to specific target groups, including children who are state wards, children who are involved in the legal system, and children with families with no insurance or financial resources. This gap in service exists primarily because the need is great and funding resources are limited. Therefore, funds have been targeted to provide services for very specific groups of children and their families. Unfortunately, one way to access services for children is for parents to relinquish custody of their children, deeming them state wards, and making them eligible for services. Another circumstance is allowing children to fail to the point where they violate the law. Children then fall into one of the designated service categories and are able to access services. This is not an acceptable state of affairs. Appropriate service models are effective and available (Professional Partner, Integrated Care Coordination), but without adequate funding to serve children in need, we will continue to pay the price later by forcing children into higher levels of care and/or into the legal system. Additionally, Nebraska recently (August 2002, Special Session of the Legislature) reduced the budget for Medicaid services, reducing the eligibility for Medicaid from 180% of the poverty level to 125% for families. This disqualifies many children and families from receiving Medicaid. We anticipate this reduction will increase the burden on the public system to ensure that children and families' behavioral health needs are met.

DEVELOPMENTALLY APPROPRIATE SERVICES FOR YOUTH IN TRANSITION
Additional assessment of the ability of adult providers to work successfully with transitioning is needed to ensure developmental appropriateness of services. Adult providers are often unwilling to serve younger adults as their developmental needs are different than older adults, and/or should be met in a different manner than older adults' needs.

FY2003 GOALS FOR CHILDREN OR ADOLESCENTS

Goal 1: To provide comprehensive, community-based family support
Goal 2: To expand mental health services to youth in the juvenile justice system
Goal 3: To increase the number of children receiving integrated service coordination
Goal 4: Expand wraparound to rural population
Goal 5: Maintain or increase the Per Capita State Expenditures for Community Mental Health Services

**ACCOMPLISHMENTS**
**Goal 1: Comprehensive, community based family support Objective Achieved**

The Office of Protection and Safety and the Office of Mental Health, Substance Abuse and Addiction Services offered a proposal to solicit bids for a new support activity called **"Families Mentoring & Supporting Other Families"**, a joint initiative to request proposals from qualified sources to provide:

A. Strength-based, family centered, and partnership oriented supports to:
   1) parents across the State of Nebraska whose children have been made state wards, or are in a voluntary case, or
   2) parent who are involved with the department as a result of a report of abuse/neglect, or
   3) parents whose children are diagnosed with a serious emotional disturbance and substance dependence disorders.
B. The intent is to ensure that parents have a voice, ownership and access to the systems of care for their child (i.e. case plans, individual educational plans, treatment plans and any other care plan).

The Department sought organizations interested in working with the State to build support services to families that will focus on providing parents with an understanding of wraparound services through peer role modeling and coaching. The philosophy of wraparound includes individualized services that are developed through professionals and parents in partnership where both are serving important roles in service delivery. Services are tailored to meet the individualized needs of the child and family and based upon strength-based assessments.

The outcomes for parents served will be:

1. To have support of other families that are coping with similar challenges.
2. To reduce parental feelings of emotional and social isolation that sometimes occur in parenting a child with emotional and behavioral challenges.
3. To have referral sources to access the appropriate services for their child and other family members.
4. To be equal partners in the system of care.
5. To learn how to enhance communication and networking with the professionals involved in the case.

The program objectives are to form one parent organization within each of the service areas/regions, for all individual parent organizations awarded contracts to come together and form a consortium so there is some commonality and consistency between the 6 service areas/regions organizations and an opportunity for statewide issues to be addressed. HHS will have a collaborative relationship with the consortium. The consortium members may be required to meet with HHS via telephone conference calls on a quarterly basis and in-person one-two times per year. They will deliver parent to parent supports that are efficient, effective and responsive as well as tailored to the unique and individualized needs of the child and family and measure and demonstrate the parent outcomes outlined above.

Supports provided to parents will include:

- one on one mentoring and coaching of parents by other parents that have/are experiencing similar issues;
- contact with the family (frequency and type to be determined by the family) if the family chooses to have such home visits and/or phone calls;
- general advocacy and support (i.e. at child/family team meetings)
- training and empowerment resulting in effective working relationships with case managers, teachers and other professionals;
- help identify family strengths to nurture positive team interactions
- education regarding parental rights and responsibilities as it relates to Nebraska HHS systems of care;
- assistance in interpreting the case plan, court documents, the Individual Educational Plan (IEP) process, medical documents and service/treatment plans; and
- professional referral resources as appropriate per individual child/family needs. (i.e. navigating to other available resources and opportunities)
- coordinate volunteers to assist with parent supports

All supports are required to be community-based and provided at the local community level. Organizations must ensure supports have the capacity to address the unique culture of each family and child. Organizational supports need to recognize the importance of understanding the values, beliefs, and practices of diverse cultures. Organizations must integrate diversity into their practices and products so that interactions with individual children and their families can be mindful of, and honor, the family's home culture.

One organization has been selected from each of six service areas of Health and Human Services and the corresponding mental health and substance abuse regions to develop a program that will provide supports to targeted families (1) whose children have been made state wards, (2) are involved with the department as a result of a report of abuse/neglect, or (3) whose children are diagnosed with a severe emotional disturbance and substance dependence disorders.

Family organizations selected for this proposal are also targeted to contract with the Integrated Care Coordination Units funded by the Office of Protection and Safety to perform various responsibilities in support of families for the ICCUs. Receiving funding for different initiatives increases the financial viability of the parent organizations.

Additionally, the Munroe Meyer Institute – University of Nebraska Medical Center and Parent Training and Information of Nebraska have developed and piloted a family led mentoring system

for families of all cultures of children with disabilities who need flexible, family centered support services. The **"Families Unite" Project** matches trained mentors with newly identified parents and families. It is the goal of the project to assist families in accessing services and advocating for their family member with a disability. The philosophy, like other mentor projects nationwide, is based on the belief that one of the most meaningful sources of support for a family with a child with a disability are other parents who have experienced parenting a child with a disability. The project is based on a needs assessment survey , initiated in the fall of 2001, the Unite Council review and small work group recommendations. There are guidelines and responsibilities to help make this experience meaningful and productive.

A Project Coordinator will be responsible for assigning all matches. Before making any match, the project coordinator will consider the interests, skills, background, time availability, personal preferences and knowledge of both the parent mentor and the family seeking a mentor. The Family Mentor Pilot Project will provide all training to the mentors. The mentors are required to attend all training and networking sessions. All mentor candidates with be supplied with a detailed application form, self assessment form, and a reference form. The information from these forms will be sent to the funding source. Once all information has been received the application will be forwarded for approval to become a mentor. Once the mentor application has been approved the Project Coordinator will begin the matching process which is designed to meet the individual and specific needs of families.

The Project Coordinator will match a family regarding their specific needs. It is imperative that the mentor keep the Project Coordinator informed of the monthly activities regarding assisting the family meeting their specific needs. All information shared by the Project Coordinator about the family is strictly confidential; a mentor sharing information with others may inadvertently violate the law. The mentor should be clear with the parent(s) or family that the mentor **cannot** legally keep information regarding sexual, emotional, or physical abuse confidential. The mentor should immediately report such information to a project coordinator, making a note as to when the information was reported and to whom.

The project will be providing a monthly stipend to the mentor for services provided. Therefore, the mentor will refrain from giving and receiving payments of any kind (i.e. gifts of money, food, extravagant outings, presents or fees). The project will provide mentors with training regarding personal and family rights and responsibilities. The mentor therefore must respect the rights and wishes of the parent/family. One must be careful of making judgmental assumptions. Mentors will be paid a stipend by the project to participate in training and networking sessions. All training sessions are mandatory. When mentors are matched with families they will be paid a stipend for the month(s) they are mentoring a family. Matching is done on an individual basis. Everyone may not be able to be matched, you may in the end not be matched and stipends will discontinue at that time. If the funding of the grant ends, the funds will end for stipends for training and mentoring a family.

Mentors will be available to families as reasonably needed. Mentors will complete 3 training modules before they may be matched with a parent/family. After matching, mentors will continue to meet with the Project Coordinator once a month for on-going support and training. This time offers mentors and the Project Coordinator the opportunity to discuss and monitor on-going progress, problems and victories of the mentoring relationship. Mentors are also expected and encouraged to participate in special family mentor projects events from time to time.

Overall objectives of the Families Unite proposal include continuance of Unite's Family Policy Council to guide the project, implementation of the family mentor system and evaluation of the

feasibility of the pilot to demonstrate the benefits of the family mentor system to both families and state service systems. Source: Proposal for UNITE, Family Mentor Pilot Project, May, 2002.

Changes in Implementation Strategy: No significant changes in the implementation strategy

Innovative or Exemplary Models:
The development of the family support in Nebraska has been recognized as a unique and innovative approach by national organizations. Instead of developing an organization from the top down, the creation of family support in Nebraska has been a grass roots effort from the bottom up. Local family members created their own local organizations at the regional level, and these local organizations developed the statewide organization. In addition, the statewide family conference has continued to draw increased numbers of family members over the years, including 2003. The role of local family organizations in the evaluation of systems of care has been highlighted at a number of national conferences. Finally, the parent to parent support offered by the local organizations has been recognized as exemplary practice by the Governor and state agencies.

Goal #2: Expand Mental Health Services to children in the juvenile justice /child welfare systems
Objective Achieved

Nebraska has achieved this objective through a number of activities:

New programs for target children within the juvenile justice system continue to be developed. One such funding initiative is the Violent Offender Incarceration/Truth-in-Sentencing (VOI/TIS) Federal Grant. VOI/TIS funding is offered by the federal government to assist states in addressing issues of violent offenders and overcrowding in their juvenile correctional facilities. Nebraska was awarded VOIT/TIS funding in the amount of approximately $4 million to increase bed capacity for violent juvenile offenders and to address issues of overcrowding in the Youth Rehabilitation and Treatment Center (YRTC) in Kearney. Nebraska is required to provide a 10% match. Nebraska identified two specific services to assist the YRTC in Kearney to address their overcrowding. HHS/OJS and the facility are working to implement and operationalize these two programs at the present time. One program being established is a sexual offender program, and the other is a culturally sensitive transitional program for African-American youth. All youth referred to either of these programs will remain committed to the YRTC-K, but be served at a site other than the main campus. The alternative site programs will be self-contained and offer specialized services to meet the behavioral, emotional, and physical needs of these particular youth.

The Sexual Offender Program will be located in Lincoln and will be able to serve approximately 7-9 male juveniles. Youth in this program will have significant functional impairments due to emotional disorders, as well as cognitive and/or sexual behavioral impairments. They will have persistent patterns of disruptive behavior and disturbance in age-appropriate adaptive functioning, and be at very high risk for causing harm to self or others. Youth will receive specialized services to address their sexual offender issues and other issues impacting their daily functioning.

The Transitional Living Program will be located in Omaha and will be able to provide culturally sensitive alternative programming for 8-10 African-American juvenile males instead of traditional programming at YRTC-Kearney. This program will concentrate on teaching these youth viable independent living skills for success in the future and to divert them from any future delinquent behaviors. Youth in this program will also have significant functional impairments due to emotional disorders and possibly have cognitive impairments. They will have persistent patterns of disruptive behaviors, disturbance in age-appropriate adaptive functioning, and be at risk for causing

harm to self or others. In addition, they will receive services to improve upon their lack of vocational, interpersonal, and social skills generally considered necessary to live in the mainstream of society and be drug-free, free of criminal behavior, and legitimately successful. Offering such a culturally sensitive program will also enable the department to begin to address the issue of disproportionate minority confinement (DMC). Although these programs offer exciting opportunities for youth targeted to be served, they are reactive in nature as youth must be in the juvenile justice system to participate. It is our hope that a less reactive, more proactive approach can be added to the service array to intervene before crisis occurs.

**Changes in Implementation Strategy: No significant changes in the implementation strategy**

Goal: A System Integrated Services Objective Achieved

**Nebraska has achieved this objective through a number of activities:**

A primary initiative in integration of care for children and adolescents in Nebraska has been the development of Integrated Care Coordination Units. The Department of Health and Human Services in partnership with Region III Behavioral Services developed a proposal to integrate care for children in the child welfare/juvenile justice system. Integrated care coordination is designed to effectively manage the care of children and families with multiple and complex needs at the local level. The Individualized System of Care initiative is designed to serve 201 high-need children in Central Nebraska who are wards of the state. The youth are those in Agency-Based Foster Care (therapeutic foster care) and higher levels of care. Funding is through a case rate based on 95% of the cost of serving these youth during FY00. This project utilizes an integrated care coordination collaborative that includes Protection and Safety Workers (child welfare and juvenile justice system), Professional Partners (mental health and substance abuse service system), School-Based Wraparound Teams (education system), Families CARE Partners (family members partner with public system care coordinators to provide additional support and advocacy for families served in the program), and Community Wraparound Teams (teams that identify and support a wraparound team to assist children and families in need. The team mobilizes informal supports that remain with the child and family far beyond the time formal services are discontinued).

The integrated service delivery system was developed to include the following components:

Integrated service delivery in which service providers work together to coordinate service delivery

- Families working together to ensure the voices of parents are heard
- Communities working together with families and providers to ensure support for children
- Child-funding agencies working with each other and with families, providers and communities to ensure coordinated policies, funding, and system development.

In FY03, Regions 1, 4, and 6 implemented Integrated Care Coordination in their respective regions. Currently, 300 additional children are served by Integrated Care Coordination.

Goal #4: Expand Wraparound Services to Children Objective Achieved

**Nebraska has achieved this objective through a variety of activities:**

Previous state plans have supported the development of wraparound to support children and families of seriously emotionally disturbed children and their families. During the summer of 1994, Nebraska's Governor hosted a Child and Family Mental Health Search Conference. The impetus of the conference was that mental health service systems were fragmented and unconnected, and policy development was conflicting and uncoordinated. Seventy key leaders were brought together for the purpose of developing a shared commitment to build an integrated system to promote the provision of high quality, seamless, mental health services for children and families.
*Participants identified the following as being crucial for an integrated system of care:*

- A clear point of access to services 24-hours a day, 7 days a week;
- A Professional Partner to assist families in navigating the system;
- A single, coordinated assessment addressing multiple agency requirements;
- Flexible funding, not tied to specific service categories, but used for creative services and supports unique to each child and family's needs;
- Regional Human Service Districts that integrate mental health, child welfare, juvenile justice, and education which blend and jointly administer funds; and
- Outcome-based accountability.

From these key components the Nebraska Professional Partner Program was developed, serving Nebraska families who have children or adolescents needing mental health services. Professional Partner Programs are located in each of Nebraska's six Mental Health Regions.

**Wraparound for children with complex needs and their families included the development of the following components:**

- Wraparound efforts must be based in the community
- Services and supports are individualized, built on strengths, and meet the needs of individuals and families across the life domains to promote success, safety, and permanency in home, school or work, and community.
- The process must be culturally competent, building on the unique values, preferences, and strengths of children and their families.
- Individuals and/or families have a high level of decision-making power at every step of the wraparound process.
- The wraparound approach must be a team driven process involving the family, individual, natural supports, agencies and community services working together to develop, implement, and evaluate the individualized support plan.
- Wraparound teams must have flexible approaches and flexible funding to implement individualized support plans.
- Wraparound plans must include a balance of formal services and informal community and family resources
- Community agencies and team members are persevering in their commitment to the individual and family
- An individualized support plan is developed and implemented on an interagency, community-neighborhood collaborative process.
- Outcomes are determined and measured for the individual and family.

Funds became available July 1, 1995, and the Program has served 1,163 families since it's inception. Outcomes indicate children and families are satisfied with the services they receive, feel included in the planning efforts, and believe they are doing better as a result of the Program. Data also indicates a significant level of improvement in the youth's functioning during service in the Professional Partner Program.

One of the most effective efforts at serving children with serious emotional disorders **in rural areas of the state** has been the development of school-based wraparound. School-based wraparound is another important variation of the wraparound process. A major issue with many wraparound-planning efforts involves the intersection of the community, social service providers, and the schools. One of the most difficult problems is engaging school personnel to become full partners in the wraparound process. Developing a school-based support plan, as part of an overall wraparound plan is often complex due to language and system barriers between schools and other child and family team members. The wraparound approach must include improved academic performance as well as behavioral functioning for children.

During FY 2001, the Department began funding a school-based program in Region I. This program in the Chadron School District is currently providing services to 11 youth and families. The community of Chadron has a population of approximately 6000 people in and is located in the frontier area of western Nebraska. The school based program is based upon the wraparound approach to service delivery relying on the natural support systems of the family, neighborhood and community which may be the only supports available in a rural setting. The program holds the belief that as the needs of the child and his or her family become more complex, the interventions, services and supports they receive will become more individualized. The team approach ensures that families have a voice, ownership, and access to a comprehensive, individualized support plan. The school-based program gives priority to families and/or schools in need of enhanced collaboration between the two parties. Also, to students who demonstrate significant school impairments as evidenced by academic failures, behavior challenges in the school setting and truancy.

In FY02, Nebraska has made progress in expanding rural school wraparound services. In March of FY02, Region 4 received $78,000 to expand school wraparound to northeast areas of Nebraska. Norfolk, located in rural northeast Nebraska, has seen a significant rise in the Hispanic population in the last five years. In cooperation with Norfolk Public Schools, the Region 4 wraparound program utilizes the principles as the Professional Partner program and works to serve students through the school based setting. The program hopes to serve students who are challenged by lack of access to traditional services as well as language barriers. IN FY02, three student s were enrolled in the program. In FY03, the Region 4 wraparound program served a total of 16 youth, an increase of 13 youth over last year.

**Changes in Implementation Strategy: No significant changes in the implementation strategy**

Innovative or Exemplary Models:
Nebraska continues to support a number of exemplary wraparound models:

- The Professional Partner Program has been mentioned by the Governor as a model program in Nebraska which meets the needs of children with serious emotional disorders and their families.
- Nebraska is unique in developing an integrated wraparound/MST model. This model has been presented at numerous national conferences and has been discussed in professional journals

- School-based wraparound is an innovative collaborative approach that has been expanding in Nebraska. This model has also been presented at a number of national conferences and is being presented in a promising practices monograph.
- Development of wraparound in cultural centers has been identified as an exemplary approach by federal site reviewers. This model will be studied by other states who wish to provide cultural competent wraparound services.
- CO-OP for Success, the wraparound project that integrates mental health, vocational rehabilitation, and schools has been identified in a statewide newsletter as a model program.
- The program evaluation component of the Professional Partner Program and the Children's Mental Health grant sites has been presented at national conference and received much acclaim. The unique features include wraparound fidelity measurements, the use of client based data to inform plan of care development, the use of strength-based assessments, and the system of care comparison study.

**Goal 5: Maintain or increase the Per Capita State Expenditures for Community Mental Health Services**

| State Expenditures for Children's Services | | | |
|---|---|---|---|
| Calculated 1994 | Actual 2002 | Actual / 2003 * | % Achieved |
| **$620,801** | **$3,793,391** | **$3,872,010** | |

It should be noted that in the FY03 Mental Health Block Grant application, the Expenditures reported were estimated. The corrected amount expended for FY03 is reported above. An additional $1,500,000 was expended from a CMHS special children's grant. FY03 was the final year of the grant, but some carryover funds remain; therefore, it is not included in the base actual or estimated expenditures. Local contractors have the flexibility to contract per the local priorities and needs in adult and children's services; therefore, the amount of funds contacted may fluctuate between adults and children's services annually.

**Changes in Implementation Strategy: No significant changes in the implementation strategy**

Innovative or Exemplary Models: NA

**FIVE CRITERIA**

**Criterion 1: Comprehensive Community- based Mental Health Service Systems-**

| | | | | |
|---|---|---|---|---|
| **GOAL #1:** | To provide comprehensive, community-based family support for families of children with emotional, behavioral, and mental health issues. | | | |
| **POPULATION:** | Family members of children and adolescents with serious emotional and behavioral disorders | | | |
| **OBJECTIVE:** | The number of families participating in family support groups will increase by 5%. | | | |
| **CRITERION:** | #1 Comprehensive, community-based mental health system | | | |
| **BRIEF NAME:** | Family members in support groups | | | |
| **INDICATOR:** | The average number of persons participating in family support groups | | | |
| **MEASURE:** | Count of average number of persons participating in support groups offered by Nebraska Federation of Families | | | |
| **SOURCE OF INFORMATION:** | Nebraska Federation of Families Reports | | | |
| **SIGNIFICANCE:** | Nebraska families have indicated that family support groups are a high need area and beneficial in supporting families | | | |
| **1. Performance Indicator** | **2. FY 2001 Actual** | **3. FY 2002 Actual** | **FY 2003 Actual** | **% Attain** |
| Family members in support groups | **138** | **198** | **212** | **101%** |

**Criterion 2: Mental Health System Data Epidemiology**

**GOAL #2:** To expand mental health services to all children with mental health problems including youth in the juvenile justice/child welfare (Protection & Safety) system.

**POPULATION:** Children with serious emotional disorders

**OBJECTIVE:** The number of children served in Multisystemic Therapy will increase by 5%.

**CRITERION:** Prevalence and treated prevalence of mental illness

**BRIEF NAME:** Multisystemic Therapy for children with SED

**INDICATOR:** The number children served in Multisystemic Therapy

**MEASURE:** Count of children in Multisystemic Therapy

**SOURCE OF INFORMATION:** MST Teams

**SIGNIFICANCE:** Body of research indicates Multisystemic Therapy is effective for youth with serious emotional disturbance and conduct disorders and those involved in juvenile justice

| 1. Performance Indicator | 2. FY 2001 Actual | 3. FY 2002 Actual | FY 2003 Actual | % Attain |
|---|---|---|---|---|
| Number of children served in MST | 116 | 101 | 72 | 71% |

In November, 2003, six new providers for Multisystemic Therapy were approved in order to achieve the objective of increasing the number of youth served using MST. It was the intent of the Protection and Safety System, who issued the RFP, to fund the service using Medicaid funds. Due to state budget cuts in FY03, Medicaid funding for children and families actually decreased, and funds were not available for this new service without reducing other necessary behavioral health services. Multisystemic Therapy continues to be funded by the Nebraska Behavioral Health System (public, non-Medicaid funds). However, even with state budget cuts Nebraska was able to serve 72 youth with Multisystemic Therapy Teams.

**Criterion 3: Children's Services**

**GOAL #3:** To provide a system of integrated services for all children with serious emotional disorders who have multiple and complex needs

**POPULATION:** Children with serious emotional disorders who are wards of the state

**OBJECTIVE:** The number of children who are in the custody of the state and who receive integrated care coordination will increase by 193 (target total 415).

**CRITERION:** Children's Services

**BRIEF NAME:** Integrated care coordination for state wards with SED

**INDICATOR:** The number of children receiving integrated care coordination

**MEASURE:** Count of children receiving integrated care coordination

**SOURCE OF INFORMATION:** Program evaluation reports

**SIGNIFICANCE:** Emerging body of research indicates intensive case management using the wraparound approach can be effective in ensuring appropriate services and reducing expenses of using high cost services

| 1. Performance Indicator | 2. FY 2001 Actual | 3. FY 2002 Actual | FY 2003 Actual | % Attain |
|---|---|---|---|---|
| Number of wards in ICC | 150 | 222 | 666 | 160% |

**Criterion 4: Targeted Services to Rural and Homeless Populations**

**GOAL #4:** To expand wraparound services to all children with serious emotional disorders including children from rural or other under served areas.

**POPULATION:** Children with serious emotional disorders

**OBJECTIVE:** The number of children in under served areas receiving school wraparound services will increase by 10.

**CRITERION:** Targeted Services to Rural and Homeless Populations
**BRIEF NAME:** School wraparound services

**INDICATOR:** Number of children with serious emotional disorders receiving school-based wraparound services

**MEASURE:** Count of children receiving school-based wraparound services

**SOURCE OF INFORMATION:** Professional Partner information system

**SIGNIFICANCE:** Assuring access to case management services for children with serious emotional disorders is a primary goal of the mental health block grant law. School-based wraparound also meets the state goal of expanding wraparound services.

| 1. Performance Indicator | 2. FY 2001 Actual | 3. FY 2002 Actual | FY 2003 Actual | % Attain |
|---|---|---|---|---|
| Number of children in school wrap | 90 | 102 | 145 | 129% |

**Criterion 5: Management Systems**

**GOAL:** At least maintain the Per Capita State Expenditures for Community Mental Health Services

**OBJECTIVE:** By June 30, 2003, there will be at least the same level of spending in per capita state expenditures for children's community mental health services at $8.82.

**POPULATION:** Total children's population ages 0-17 years.

**Per Capita State Expenditures for Community Mental Health Services**
Numerator = Mental Health State Expenditures (as reported for the Maintenance of Effort section of the Block Grant Application)
Data source: Office of Mental Health, Substance Abuse and Addiction Services
Denominator = per Capita ...Total children's population ages 0-17 years (450, 242)
Data Source: Nebraska Databook, Last Updated on 5/21/01 based on data from U. S. Bureau of the Census Web site (www.census.gov) 2001 <http://info.neded.org/stathand/bsect8.htm >.

| Performance Indicator: (1) | **FY 2001** Actual (2) | **FY2002** Actual (3) | **FY2003** Actual (4) | % **ATTAIN** (5) |
|---|---|---|---|---|
| Value: | $8.09 | $8.43 | $8.60 | 102% |
| Numerator | $3,643,052 | 3,793,931 | $3,872,010 | |
| Denominator | 450,242 | 450,242 | 450,242 | |

*Note: This figure is a typographical error; as you will note, the intent is to maintain or increase the level of spending which for FY02; maintenance of spending would indicate $8.43 per child. Nebraska increased the expenditures per child to $8.60.

## SECTION FIVE:
## UNIFORM REPORTING TABLES

**Uniform Reporting System (URS) "Basic Tables"**

| | |
|---|---|
| Report Year: | FY2003 |
| State Identifier: | NE |

At this time Nebraska does not have the capacity to report an unduplicated count for the State Psychiatric Hospitals and the Community Based programs. Therefore, State Psychiatric Hospital data are reported separately from community data. The AIMS database was used to report the State Psychiatric Hospitals. The Magellan Behavioral Health database was used to report Community Mental Health Services.

**AIMS Data Only / State Psychiatric Hospitals** means:

**Table 2A., Table 3B., and Table 6. (State Hospitals only).**

Data collected using software titled "Advanced Institutional Management Systems" (AIMS Data). This is the current data system used by the three State of Nebraska Psychiatric Hospitals (Hastings Regional Center, Lincoln Regional Center, Norfolk Regional Center).

**Magellan Data Only / Community Mental Health Services**

**For Table 2.A, Table 2.B, Table 3.A, Table 3.B, Table 4., Table 5.A, Table 5.B, and Table 6 (Community Programs Only).**

- **Magellan Data Only** means:
  Magellan Behavioral Health (Magellan Data) – The Nebraska Department of Health and Human Services (HHS) Office of Mental Health, Substance Abuse and Addiction Services has a contract with Magellan Behavioral Health for managed care Administrative Services Only (ASO) services. The contract includes the operation of the current data system used for Community Mental Health and Substance Abuse services. It also covered a portion of the three Regional Centers.

- **Community Mental Health Services** means:
  For this report, only community mental health (MH) clients are reported.
  Among the 15,602 served:
  → Community Services (CS) only: 15,551
  → Both Community Services (CS) and Regional Centers (RC): 51

  The number 15,602 is the number of community service only plus the number of both community service and regional centers. 15,551(CS only) + 51 (both CS and RC) = 15,602. This number will be reported as **"Community Mental Health Services"**

  F = Female
  M = Male
  Unk = Unknown
  N/A = Not Available

**Table 1. Profile of the State Population by Diagnosis**

This table summarizes the estimates of adults residing within the State with serious mental illness (SMI) and children residing within the state with serious emotional disturbances (SED). The table calls for estimates for two time periods, one for the report year and one for three years into the future. CMHS will provide this data to States based on the standardized methodology developed and published in the Federal Register and the State level estimates for both adults with SMI and children with SED.

| Table 1. | | |
|---|---|---|
| Report Year: | 2003 | |
| State Identifier: | NE | |
| | **Current Report Year** | **Three Years Forward** |
| Adults with Serious Mental Illness (SMI) | | |
| Children with Serious Emotional Disturbances (SED) | | |

***Note: This Table will be completed for the States by CMHS.***

Note: For MHPEC Review on November 18, 2003

| | |
|---|---|
| Children with Serious Emotional Disturbances (SED) | 23,537 |
| Adults with Serious Mental Illness (SMI) | 67,701 |

YOUTH means estimated Number of Children and Adolescents, Age 9 to 17, with Serious Emotional Disturbance (SED), as of 2000.

ADULT means the number of Persons in Civilian Population with Serious Mental Illness (SMI), age 18 and older as of 2000. SMI uses an estimate of 5.4% of adult civilian population age 18+. Civilian population excludes military personal residing in the geographic area. Rationale is that these personnel are served by the Military or health insurance coverage provided by the military.

Source: Ronald Manderscheid; Center for Mental Health Services (CMHS); Substance Abuse & Mental Health Services Administration (SAMHSA); U.S. Department of Health & Human Services (January 2003).

Ronald Manderscheid <rmanders@samhsa.gov>
e-mail received 11/21/2003 12:22 PM
U.S. Department of Health & Human Services
Center for Mental Health Services (CMHS)
subject: SMI and SED Prevalence for 2002

| | |
|---|---|
| 69,648 | The Resident Population with Serious Mental Illness (SMI), 5.4% of the adult civilian population in Nebraska |
| 22,842 | Estimated Number of Children and Adolescents, Age 9 to 17, with Serious Emotional Distrubance in 2002 in Nebraska. |

**Table 2A. Profile of Persons Served, All Programs by Age, Gender and Race/Ethnicity**

*This table provides an aggregate profile of persons in the reporting year. The reporting year should be the latest state fiscal year for which data are available. This profile is based on a client receiving services in programs provided or funded by the state mental health agency. The client profile takes into account all institutional and community services for all such programs. Please provide unduplicated counts if possible.*

Please enter the "total" in the appropriate row and column and report the data under the categories listed.

| | |
|---|---|
| Table 2. | |
| Report Year: | 2003 |
| State Identifier: | NE |
| Data Source: | Magellan Data Only / Community Mental Health Services |

| | Total | | | | American Indian or Alaska Native | | | Asian | | | Black or African American | | | Native Hawaiian or Ot Islander | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Female | Male | Not Available | Total | Female | Male | Not Available | Female | Male | Not Available | Female | Male | Not Available | Female | Male |
| 0-3 Years | 92 | 133 | 20 | 245 | 2 | 0 | 0 | 0 | 0 | 0 | 8 | 17 | 0 | | |
| 4-12 years | 396 | 656 | 0 | 1052 | 7 | 17 | 0 | 3 | 3 | 0 | 29 | 49 | 0 | | |
| 13-17 years | 495 | 641 | 0 | 1136 | 24 | 15 | 0 | 2 | 2 | 0 | 25 | 26 | 0 | | |
| 18-20 years | 433 | 491 | 0 | 924 | 15 | 13 | 0 | 3 | 4 | 0 | 12 | 23 | 0 | | |
| 21-64 years | 8,259 | 7635 | 5 | 15899 | 190 | 171 | 1 | 37 | 46 | 0 | 492 | 623 | 0 | | |
| 65-74 years | 214 | 131 | 1 | 346 | 1 | 2 | 0 | 3 | 0 | 0 | 7 | 4 | 0 | | |
| 75+ years | 142 | 96 | 0 | 238 | 1 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | | |
| Not Available | 12 | 13 | 0 | 25 | 0 | 0 | 0 | 0 | 0 | 0 | 2 | 4 | 0 | | |
| Total | 10,043 | 9,796 | 26 | 19865 | 240 | 218 | 1 | 48 | 56 | - | 575 | 746 | - | - | - |

Comments on Data:

**Table 2A. Profile of Persons Served, All Programs by Age, Gender and Race/Ethnicity**

| | |
|---|---|
| State Identifier: | NE |
| **Table 2A.** | |
| Report Year: **FY2003** | |
| State Identifier: AIMS Data Only / State Psychiatric Hospitals | |

| Persons Served by Age | Total | | | American Indian or Alaska Native | | | Asian | | | Black or African American | | | Native Hawaiian or Other Pacific Islander | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | F | M | NA | F | M | NA | F | M | NA | F | M | NA | F | M | NA |
| 0-3 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 4-12 | 2 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 13-17 | 21 | 91 | 0 | 1 | 5 | 0 | 0 | 0 | 0 | 3 | 9 | 0 | 0 | 0 | 0 |
| 18-20 | 25 | 78 | 0 | 0 | 4 | 0 | 1 | 0 | 0 | 3 | 11 | 0 | 0 | 0 | 0 |
| 21-64 | 419 | 789 | 0 | 12 | 17 | 0 | 3 | 7 | 0 | 44 | 91 | 0 | 0 | 0 | 0 |
| 65-74 | 9 | 15 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 75+ | 3 | 10 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Not Available | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Total** | **479** | **985** | **0** | **13** | **27** | **0** | **4** | **7** | **0** | **50** | **111** | **0** | **0** | **0** | **0** |

**Table 2A. Profile of**

*This table provides a*
*latest state fiscal yea*
*programs provided o*
*institutional and com*

Please enter the "tota

| | |
|---|---|
| Table 2. | |
| Report Year: | |
| State Identifier: | |

Data Source:

| | her Pacific | White | | | Hispanic * *use only if data for Table 2b are not available.* | | | More Than One Race Reported | | | Other Race | | | Race Not Available | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Not Available | Female | Male | Not Available | Female | Male | Not Available | Female | Male | Not Available | Female | Male | Not Available | Female | Male | Not Available |
| 0-3 Years | | 47 | 77 | 2 | | | | | | | 7 | 12 | 0 | 28 | 27 | 18 |
| 4-12 years | | 329 | 546 | 0 | | | | | | | 18 | 35 | 0 | 10 | 6 | 0 |
| 13-17 years | | 408 | 554 | 0 | | | | | | | 32 | 37 | 0 | 4 | 7 | 0 |
| 18-20 years | | 366 | 419 | 0 | | | | | | | 26 | 27 | 0 | 11 | 5 | 0 |
| 21-64 years | | 7153 | 6332 | 2 | | | | | | | 276 | 360 | 0 | 111 | 103 | 2 |
| 65-74 years | | 188 | 118 | 0 | | | | | | | 7 | 4 | 0 | 8 | 3 | 1 |
| 75+ years | | 134 | 95 | 0 | | | | | | | 5 | 0 | 0 | 2 | 0 | 0 |
| Not Available | | 9 | 7 | 0 | | | | | | | 0 | 0 | 0 | 1 | 2 | 0 |
| Total | - | 8,634 | 8,148 | 4 | - | - | - | - | - | - | 371 | 475 | - | 175 | 153 | 21 |

Comments on Data:

**Table 2A. Profile o**

| | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| State Identifier: | | | | | | | | | | | | | |
| **Table 2A.** | | | | | | | | | | | | | |
| Report Year: **FY2003** | | | | | | | | | | | | | |
| State Identifier: AIMS | | | | | | | | | | | | | |
| **Persons Served by Age** | **White** | | | **Hispanic** | | | **More than One Race Reported** | | | **Others/ Unknown** | | |
| | **F** | **M** | **NA** | **F** | **M** | **NA** | **F** | **M** | **NA** | **F** | **M** | **NA** |
| 0-3 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 4-12 | 1 | 1 | 0 | 1 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 |
| 13-17 | 15 | 61 | 0 | 1 | 9 | 0 | 0 | 5 | 0 | 1 | 2 | 0 |
| 18-20 | 19 | 51 | 0 | 2 | 9 | 0 | 0 | 1 | 0 | 0 | 2 | 0 |
| 21-64 | 336 | 629 | 0 | 12 | 27 | 0 | 7 | 4 | 0 | 5 | 14 | 0 |
| 65-74 | 9 | 15 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 75+ | 3 | 9 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Not Available | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Total** | **383** | **766** | **0** | **16** | **45** | **0** | **7** | **11** | **0** | **6** | **18** | **0** |

**Table 2B. Profile of Persons Served, All Programs by Age, Gender and Race/Ethnicity**

*Of the total persons served, please indicate the age, gender and the number of persons who are Hispanic/Latino or not Hispanic/Latino. Total persons served would be the total as indicated in Table 2A.*

Please enter the "total" in the appropriate row and column and report the data under the categories listed.

| | |
|---|---|
| Table 2. | |
| Report Year: | 2003 |
| State Identifier: | NE |
| Data Source: | Magellan Data Only / Community Mental Health Services |

| | Not Hispanic or Latino | | | Hispanic or Latino | | | Hispanic or Latino Origin Not Available | | | Total | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Female | Male | Not Available | Female | Male | Not Available | Female | Male | Not Available | Female | Male | Not Available | Total |
| 0 - 3 Years | 57 | 92 | 1 | 9 | 10 | 0 | 26 | 31 | 19 | 92 | 133 | 20 | 245 |
| 4 - 12 years | 362 | 606 | 0 | 25 | 39 | 0 | 9 | 11 | 0 | 396 | 656 | - | 1,052 |
| 13 - 17 years | 452 | 592 | 0 | 30 | 35 | 0 | 13 | 14 | 0 | 495 | 641 | - | 1,136 |
| 18 - 20 years | 388 | 434 | 0 | 31 | 33 | 0 | 14 | 24 | 0 | 433 | 491 | - | 924 |
| 21-64 years | 7642 | 6971 | 2 | 306 | 332 | 0 | 311 | 332 | 3 | 8,259 | 7,635 | 5 | 15,899 |
| 65-74 years | 203 | 122 | 0 | 4 | 6 | 0 | 7 | 3 | 1 | 214 | 131 | 1 | 346 |
| 75+ years | 136 | 93 | 0 | 2 | 0 | 0 | 4 | 3 | 0 | 142 | 96 | - | 238 |
| Not Available | 10 | 12 | 0 | 0 | 1 | 0 | 2 | 0 | 0 | 12 | 13 | - | 25 |
| Total | 9,250 | 8,922 | 3 | 407 | 456 | - | 386 | 418 | 23 | 10,043 | 9,796 | 26 | 19,865 |

State Comments on Data:

**Table 3A. Profile of Persons served in the community mental health setting by homeless status.**

*This table provides a profile for the clients that received public funded mental health services in community mental health setting by Homeless and Non-Homeless status. A person receiving services in the community should be counted in the "Homeless" category if he/she was reported homeless at their most recent assessment during the reporting period.*

| **Table 3A. Community/A** | |
|---|---|
| Report Year: | 2003 |
| State Identifier: | NE |
| Data Source: | Magellan Data Only / Community Mental Health Services |

| **Table 3A.** Community/Ambulatory By Homeless Status. | **Age 0-17** | | | **Age 18-20** | | | **Age 21-64** | | | **Age 65+** | | | **Age Not Available** | | | **Total** | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | **Female** | **Male** | **Not Available** | **Female** | **Male** | **Not Available** | **Female** | **Male** | **Not Available** | **Female** | **Male** | **Not Available** | **Female** | **Male** | **Not Available** | **Female** | **Male** | **Not Available** | **Total** |
| Homeless | 4 | 22 | 0 | 19 | 16 | 0 | 525 | 816 | 0 | 4 | 0 | 0 | 1 | 1 | 0 | 553 | 855 | - | 1,408 |
| Non-Homeless | 953 | 1384 | 2 | 414 | 472 | 0 | 7657 | 6739 | 4 | 338 | 224 | 0 | 10 | 12 | 0 | 9,372 | 8,831 | 6 | 18,209 |
| Homeless Status Not Available | 0 | 4 | 0 | 0 | 0 | 0 | 19 | 23 | 0 | 2 | 0 | 0 | 0 | 0 | 200 | 21 | 27 | 200 | 248 |
| Total | 957 | 1,410 | 2 | 433 | 488 | - | 8,201 | 7,578 | 4 | 344 | 224 | - | | | | 9,946 | 9,713 | 206 | 19,865 |

**How Often Does your State Measure Homeless Status?** ☑ At Admission ☑ At Discharge ☐ Monthly ☐ Quarterly ☐ Other: describe: _____

**State Comments on Data:** Note Data Source: Magellan Data Only / Community Mental Health Services

**Table 3B: Profile of persons served in state psychiatric hospitals and other inpatient settings.**

source: AIMS Data Only / State Psychiatric Hospitals

*This table provides a profile of the patients that received public funded mental health services in state hospital and/or other inpatient settings that are part of the SMHA mental health system. Persons admitted to hospitals more than once during the fiscal year should be counted only once in either one or both (if applicable) rows.*

| **Table 3B.** Profile of Persons Served in Psychiatric Inpatient Settings | **Age 0-17** | | | **Age 18-20** | | | **Age 21-64** | | | **Age 65+** | | | **Age Not Available** | | | **Total** | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | **Female** | **Male** | **Not Available** | **Female** | **Male** | **Not Available** | **Female** | **Male** | **Not Available** | **Female** | **Male** | **Not Available** | **Female** | **Male** | **Not Available** | **Female** | **Male** | **Not Available** | **Total** |
| State Psychiatric Hospita | 23 | 93 | 0 | 25 | 78 | 0 | 419 | 789 | 0 | 12 | 25 | 0 | 0 | 0 | 0 | 479 | 985 | 0 | 1,464 |
| Other Psychiatric Inpatie | NA | NA | NA | NA | NA | NA | NA | NA | NA | NA | NA | NA | NA | NA | NA | NA | NA | NA | NA |
| RTCs for Children | NA | NA | NA | NA | NA | NA | NA | NA | NA | NA | NA | NA | NA | NA | NA | NA | NA | NA | NA |
| Total | 23 | 93 | - | 25 | 78 | - | 419 | 789 | - | 12 | 25 | - | - | - | - | 479 | 985 | - | 1,464 |

State Comments on Data: Note Data source: AIMS Data Only / State Psychiatric Hospitals … NE does not have the capacity to report "Other Psychiatric Inpatient or RTCs for Children.

**Table 4. Profile of Adult Clients by Employment Status**

*This table describes the status of adults clients served in the report year by the public mental health system in terms of employment status. The focus is on employment for the working age population, recognizing, however, that there are clients who are disabled, retired or who are homemakers, care-givers, etc and not a part of the workforce. These persons will be reporting in the "Not in Labor Force" category. This category has two subcategories: retired and other. (The totals of these two categories should equal the number in the row for "Not in Labor Force".) Unemployed refers to persons who are looking for work but have not found employment.* **Data should be reported for clients in non-institutional settings at time of discharge or last evaluation.**

| **Table 4** | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Report Year: | 2003 | | | | | | | | | | | | | | | |
| State Identifier: | NE | | | | | | | | | | | | | | | |
| | **18-20** | | | **21-64** | | | **65+** | | | **Age Not Available** | | | **Total** | | | |
| **Adults Served** | Female | Male | Not Available | Female | Male | Not Available | Female | Male | Not Available | Female | Male | Not Available | Female | Male | Not Available | Total |
| **Employed:** Competitively Employed Full or Part Time (includes Supported Employment) | 160 | 144 | 0 | 2758 | 2624 | 0 | 30 | 27 | 0 | 2 | 2 | 0 | 2,950 | 2,797 | - | 5,747 |
| **Unemployed** | 83 | 107 | 0 | 2043 | 2050 | 1 | 37 | 14 | 0 | 5 | 1 | 0 | 2,168 | 2,172 | 1 | 4,341 |
| **Not In Labor Force:** Retired, Sheltered Employment, Sheltered Workshops, Other (homemaker, student, volunteer, disabled, etc.) | 189 | 237 | 0 | 3377 | 2865 | 3 | 273 | 182 | 0 | 4 | 10 | 0 | 3,843 | 3,294 | 3 | 7,140 |
| **Not Available** | 1 | 0 | 0 | 66 | 91 | 0 | 14 | 3 | 0 | 1 | 0 | 28 | 82 | 94 | 28 | 204 |
| **Total** | | | | | | | | | | | | | 9,043 | 8,357 | 32 | 17,432 |

State Comments on Data: Note Data Source: Magellan Data Only / Community Mental Health Services.
Youth (Age <17) = 2433; Grand Total = 17432+2433=19865

**Table 5A. Profile of Clients by Type of Funding Support**

*This table provides a summary of clients by Medicaid coverage. Since the focus of the reporting is on clients of the public mental health service delivery system, this table focuses on the clientele serviced by public programs that are funded or operated by the State Mental Health Authority. Persons are to be counted in the Medicaid row if they received a service reimbursable through Medicaid.*

*Please note that the same person may be served in both Medicaid and Non-Medicaid programs during the same reporting period.*

| | |
|---|---|
| Table 5A | |
| Report Year: | 2003 |
| State Identifier: | NE |

| | Total | | | | American Indian or Alaska Native | | | Asian | | | Black or African American | | | Native Hawaiian or Other Pacific Islander | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Female | Male | Not Available | Total | Female | Male | Not Available | Female | Male | Not Available | Female | Male | Not Available | Female | Male | Not Available |
| Medicaid (only Medicaid) | 1640 | 1398 | 4 | 3,042 | 28 | 18 | 1 | 9 | 13 | 0 | 177 | 149 | 0 | | | |
| Non-Medicaid Sources (only) | 6,447 | 6289 | 3 | 12,739 | 164 | 151 | 0 | 26 | 34 | 0 | 311 | 462 | 0 | | | |
| People Served by Both Medicaid and Non-Medicaid Sources | | | | - | | | | | | | | | | | | |
| Medicaid Status Not Available | 1,917 | 2067 | 100 | 4,084 | 48 | 48 | 0 | 13 | 9 | 0 | 86 | 134 | 0 | | | |
| Total Served | 10,004 | 9754 | 107 | **19,865** | 240 | 217 | 1 | 48 | 56 | 0 | 574 | 745 | 0 | | | |

New Rows are used for those people who can report Medicaid unduplicated. Each row would have a unique (unduplicated) count of clients: (1) Medicaid Only, (2) Non-Medicaid On (3) Both Medicaid and Other Sources funded their treatment, and (4) Medicaid Status Not Available)

If a state is unable to unduplicate between People whose care is paid by Medicaid, then they would report all data into the People Served by Both Medicaid and Other Sources and would check the box, People Served by Both is a duplicated count

**Table 5A. Profile of Cli**

*This table provides a summ*
*on the clientele serviced by*
*service reimbursable throug*

*Please note that the same*

| Table 5A |
|---|
| Report Year: |
| State Identifier: |

| | White | | | Hispanic * *use only if data for Table 2b are not available.* | | | More Than One Race Reported | | | Other Race | | | Race Not Available | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Female | Male | Not Available | Female | Male | Not Available | Female | Male | Not Available | Female | Male | Not Available | Female | Male | Not Available |
| Medicaid (only Medicaid) | 1334 | 1120 | 1 | | | | | | | 61 | 67 | 0 | 31 | 31 | 2 |
| Non-Medicaid Sources (only) | 5652 | 5290 | 2 | | | | | | | 226 | 297 | 0 | 68 | 55 | 1 |
| People Served by Both Medicaid and Non-Medicaid Sources | | | | | | | | | | | | | | | |
| Medicaid Status Not Available | 1643 | 1729 | 1 | | | | | | | 82 | 107 | 0 | 45 | 40 | 99 |
| Total Served | 8629 | 8139 | 4 | | | | | | | 369 | 471 | 0 | 144 | 126 | 102 |

New Rows are used for those p
(3) Both Medicaid and Other S

If a state is unable to unduplica
would check the box, People S

**Table 5B. Profile of Clients by Type of Funding Support**

*Of the total persons covered by Medicaid, please indicate the gender and number of persons who are Hispanic/Latino or not Hispanic/Latino. Total persons covered by Medicaid would be the total indicated in Table 5A.*

*Please note that the same person may be served in both Medicaid and Non-Medicaid programs during the same reporting period.*

| | |
|---|---|
| Table 5B. | |
| Report Year: | 2003 |
| State Identifier: | NE |

| | Not Hispanic or Latino | | | Hispanic or Latino | | | Hispanic or Latino Origin Unknown | | | Total | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | **Female** | **Male** | **Not Available** | **Female** | **Male** | **Not Available** | **Female** | **Male** | **Not Available** | Female | Male | Not Available |
| Medicaid Only | 1,495 | 1257 | 2 | 55 | 38 | 0 | 90 | 103 | 2 | 1,640 | 1,398 | 4 |
| Non-Medicaid Only | 6,091 | 5888 | 1 | 269 | 319 | 0 | 87 | 82 | 2 | 6,447 | 6,289 | 3 |
| People Served by Both Medicaid and Non-Medicaid Sources | | | | | | | | | | - | - | - |
| Medicaid Status Unknown | 1,657 | 1763 | 0 | 83 | 99 | 0 | 177 | 205 | 100 | 1,917 | 2,067 | 100 |
| Total Served | | | | | | | | | | 10,004 | 9,754 | 107 |

State Comments on Data: The "People Served by Both Medicaid and Non-Medicaid Sources" were included in medicaid only and removed from Non-Medicaid Sources

Note Data Source: Magellan Data Only / Community Mental Health Services

New Rows are used for those people who can report Medicaid unduplicted. Each row would have a unique (unduplicated) count of clients: (1) Medicaid Only, (2) Non-Medicaid Only, (3) Both Medicaid and Other Sources funded their treatment, and (4) Medicaid Status Unknown)

If a state is unable to unduplicate between People whose care is paid by Medicaid, then they would report all data into the People Served by Both Medicaid and Other Sources and would check the box, People Served by Both is a duplicated count

| |
|---|
| Total |
| 3,042 |
| 12,739 |
| - |
| 4,084 |
| 19,865 |

**Table 6: Profile of Client Turnover**

| Report Yr | 2003 | | | | | | |
|---|---|---|---|---|---|---|---|
| State: | NE | | | | | | |
| **Profile of Service Utilization** | **Total Served at Beginning of Year (unduplicated)** | **Admissions During the year (duplicated)** | **Discharges During the year (duplicated)** | **Length of Stay (in Days): Discharged Patients** | | **Average Length of Stay (in Days): Residents at end of year** | |
| | | | | **Average (Mean)** | **Median** | **Average (Mean)** | **Median** |
| **State Hospitals (note 1)** | 486 | 1,245 | 1,280 | | | | |
| Children (0 to 17 years) | 11 | 130 | 115 | 56.1 | 25.0 | 77.2 | 86.5 |
| Adults (18 yrs and over) | 475 | 1,115 | 1,165 | 172.1 | 54.0 | 293.9 | 89.0 |
| **Other Psychiatric Inpatient** | - | - | - | | | | |
| Children (0 to 17 years) | | | | | | | |
| Adults (18 yrs and over) | | | | | | | |
| Residential Tx Center for Children: Children (0 to 17 years) | | | | | | | |
| **Community Programs (note 2)** | 9,135 | 17,886 | | | | | |
| Children (0 to 17 years) | 1,182 | 1,387 | | | | | |
| Adults (18 yrs and over) | 7,953 | 16,499 | | | | | |

State Comments on Data:

Note 1 - Data source: AIMS Data Only / State Psychiatric Hospitals - for "State Hospitals / Children (0-17 yrs.) / Adults (18 yrs. and over)

Note 2 - Data Source: Magellan Data Only / Community Mental Health Services - for Community Programs /

Note: Workgroup Recommended Dropping reporting on Discharges for Community Programs

## Table 7. Profile of Mental Health Service Expenditures and Sources of Funding

*This table describes expenditures for public mental health services provided or funded by the State mental health agency by source of funding.*

***This Table will be completed by the NASMHPD Research Institute (NRI) using data from the FY 2002 SMHA-Controlled Revenues and Expenditures Study***

| **Table 7** | | | | |
|---|---|---|---|---|
| **Report Year:** | 2003 | | | |
| **State Identifier:** | **NE** | | | |
| | **State Hospital** | **Other 24 Hour Care*** | **Ambulatory/ Community Non-24 Hour Care** | **Total** |
| **Total** | Data will come from the NRI's FY'2002 SMHA Revenues and Expenditures Study. | | | |
| **Medicaid** | The NRI Study is | | | |
| **Community MH Block Grant** | Currently Underway | | | |
| **Other CMHS** | | | | |
| **Other Federal (non-CMHS)** | | | | |
| **State** | | | | |
| **Other** | | | | |

** Other 24 Hour Care: is "residential care" from both state hospitals and community ("Ambulatory/Community). Thus, "Other 24 Hour Care" expenditures are also included in the state hospital and/or "Ambulatory/Community" Columns as applicable.*

State Comments on Data:

Note: The data in this table are derived from the National Association of State Mental Health Program Directors Research Institute, Inc's State Mental Health Agency-Controlled Revenues and Expenditures Study. FY'2002 Data for this table is currently being compiled by the NRI.

**Table 8. Profile of Community Mental Health Block Grant Expenditures For Non-Direct Service Activities**

*This table is used to describe the use of CMHS BG funds for non-direct service activities that are sponsored, or conducted by the State Mental Health Authority*

| Table 8 | |
|---|---|
| Report Year: | 2003 |
| State Identifier: | NE |
| Profile of Community Mental Health Block Grant Expenditures for Non-Direct Service Activities | |
| Service | **Estimated Total Block Grant** |
| MHA Technical Assistance Activities | |
| MHA Planning Council Activities | |
| MHA Administration | |
| MHA Data Collection/Reporting | |
| MHA Activities Other Than Those Above | $104,994 |
| **Total Non-Direct Services** | **$104,994** |

State Comments on Data:

Consistent with the Nebraska Adult Goal “Empower Consumers”, NE uses the 5% administration from the Community Mental Health Block Grant to pay for the two full-time Consumer Liaisons on staff. It is listed here as “other activities”. However, the source of the funds is the 5% “MHA Administration” set aside from the Community Mental Health Block Grant.

**Table 9. Public Mental Health System Service Inventory Checklist**

*This table is used to provide an overview of the range of services currently operated or funded by the State mental health agency.*
Indicate by a checkmark (X) the extent to which the services listed below are available in the State.

| | |
|---|---|
| Table 9 | |
| Report Year: | 2003 |
| State Identifier: | NE |

| | SERVICES PROVIDED THROUGH PROGRAMS THAT COVER: | | | | | |
|---|---|---|---|---|---|---|
| | URBAN AREAS | | RURAL AREAS | | | |
| Service Available Statewide | Some urban areas | All urban areas | Some rural areas | All rural areas | Service Not Available in State | Services Inventory |
| X | | | | | | Intensive Case Management |
| | X | | X | | | Intensive Outpatient |
| | X | | X | | | Assertive Community Treatment |
| X | | | | | | Emergency |
| | | | | | X | Services for persons with mental illness and Mental retardation/developmental disabilities |
| | X | | X | | | Integrated Services for Persons with Mental Illness and Substance Abuse |
| | | X | X | | | Employment/Vocational Rehabilitation |
| | | | X | | | In Home Family Services |
| | X | | X | | | School-based Services |
| | | | | | X | Consumer Run Services |
| | | | | | | **Intake, Diagnostic, and Screening Services** |
| X | | | | | | Intake/ Screening |
| X | | | | | | Diagnostic Evaluation |
| | | | | | X | Information and Referral Services |
| | | | | | | **Treatment Services** |
| X | | | | | | Individual Therapy |
| X | | | | | | Family/Couple Therapy |
| X | | | | | | Group Therapy |
| X | | | | | | Collateral Services |
| | | | | | X | Electro-convulsive Therapy |
| X | | | | | | Medication Therapy |
| X | | | | | | New Generation Medications |
| X | | | | | | Activity Therapy |
| X | | | | | | Behavioral Therapy |
| | | | X | | | Mobile Treatment Team |
| | X | | X | | | Peer Support |
| | | | | | | Psychiatric Emergency Walk-in |
| | | X | X | | | Telephone Hotline |

**Table 9. Public Mental Health System Service Inventory Checklist**

*This table is used to provide an overview of the range of services currently operated or funded by the State mental health agency.*
Indicate by a checkmark (X) the extent to which the services listed below are available in the State.

| | |
|---|---|
| Table 9 | |
| Report Year: | 2003 |
| State Identifier: | NE |

| | SERVICES PROVIDED THROUGH PROGRAMS THAT COVER: | | | | | |
|---|---|---|---|---|---|---|
| | URBAN AREAS | | RURAL AREAS | | | |
| Service Available Statewide | Some urban areas | All urban areas | Some rural areas | All rural areas | Service Not Available in State | Services Inventory |
| | | | | | | **Rehabilitation Services** |
| | X | | X | | | Vocational rehabilitation Services |
| | X | | X | | | Supported Employment Services |
| X | | | | | | Education Services |
| X | | | | | | Psychiatric Rehabilitation |
| X | | | | | | Case Management Services |
| X | | | | | | Family Support Services |
| X | | | | | | Wrap Around Services |
| | | | | | X | Legal Advocacy |
| | | | | X | | Drop-in Center |
| X | | | | | | General Support |
| | | X | X | | | Intensive Residential Services |
| X | | | | | | Supportive Residential Services |
| | | X | X | | | Housing Services |
| | | | | | X | Respite Services (Non-Residential) |
| | X | | X | | | Respite Residential Services |
| | | | | | X | Therapeutic Foster Care |
| | | | | | X | Foster Care |
| | | | | | | **Other Services** |
| X | | | | | | Supported Housing |
| | | X | | | | Partial Hospitalization |
| | | X | | | | Day Treatment |
| X | | | | | | Community Support |
| X | | | | | | Community Support, per diem |
| | | | | | | |
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| | | | | | | |

**Table 10. Profile of Agencies Receiving Block Grant Funds Directly from the State MHA**

*This table is to be used to provide an inventory of providers/agencies who directly receive Block Grant allocations.*

| Table 10 | | | | |
|---|---|---|---|---|
| Report Year: | 2003 | | | |
| State Identifier: | NE | | | |
| **Agency Name** | **Address** | **Name of Director** | **Phone #** | **Amount of Block Grant Allocation** |
| Region I Governing Board | 4110 Avenue D Scottsbluff, NE 69361 | John McVay | 308-635-3171 | $186,251 |
| Region II Governing Board | 110 North Bailey Street PO Box 1208 North Platte, NE 69103 | Larry Brown | 308-534-0440 | $187,795 |
| Region III Governing Board For Behavioral Health Services | 4009 6th Avenue, Suite 65 PO Box 2555 Kearney, NE 68848 | Beth Baxter | 308-237-5113 | $268,202 |
| Region IV Behavioral Health System | 206 Monroe Avenue Norfolk, NE 68701 | Jean Sturtevant | 402-370-3100 | $272,545 |
| Region V HumanService Program | 1645 "N" Street Suite A Lincoln, NE 68508 | CJ Johnson | 402-441-4343 | $438,759 |
| Region VI Behavioral Healthcare | 3801 Harney Street Omaha, NE 68131-3811 | Thomas Greener | 402-444-6573 | $583,228 |

- The functions of the six Regional Governing Boards and Regional Program Administrators are defined in state statute under the “Nebraska Comprehensive Community Mental Health Services Act” (§§ 71-5001 to 71-5014)

- “Name of Director” is the person appointed by the Regional Governing Board to serve as the “Regional Program Administrator”.

- Amount of Block Grant Allocation to Agency is based on FY2004 contracts. All amounts are as reported in The Nebraska FY2004 Community Mental Health Services Block Grant Application.

- For more details, see "TABLE 1: FY2004 FEDERAL MENTAL HEALTH BLOCK GRANT FUNDS (Rev 8/25/03) CONTRACTED WITH REGIONS FOR COMMUNITY MENTAL HEALTH SERVICES"

## Table 11: Summary Profile of Client Evaluation of Care

| Table 11 | | | | |
|---|---|---|---|---|
| **Year Survey was Conducted: 2003** | | | | |
| **State Identifier: Nebraska** | | | | |
| **Adult Consumer Survey Results:** | **Number of Positive Responses** | **Responses** | **Confidence Interval*** | |
| 1. Percent Reporting Positively About Access. | 373 | 493 | 4.35 | 75.7% |
| 2. Percent Reporting Positively About Quality and Appropriateness for Adults | 371 | 479 | 4.42 | 77.5% |
| 3. Percent Reporting Positively About Outcomes. | 344 | 481 | 4.41 | 71.5% |
| 4. Percent of Adults Reporting on Participation In Treatment Planning. | 316 | 486 | 4.39 | 65.0% |
| 5. Percent of Adults Positively about General Satisfaction with Services. | 393 | 493 | 4.35 | 79.7% |
| | | | | |
| **Child/Adolsecent Consumer Survey Results:** | **Number of Positive Responses** | **Responses** | **Confidence Interval*** | |
| 1. Percent Reporting Positively About Access. | 25 | 39 | 15.53 | 64.1% |
| 2.Percent Reporting Positively about General Satisfaction for Children. | 23 | 36 | 16.18 | 63.9% |
| 3.Percent Reporting Positively about Outcomes for Children. | 21 | 37 | 15.96 | 56.8% |
| 4. Percent of Family Members Reporting on Participation In Treatment Planning for their Children | 29 | 36 | 16.18 | 80.6% |
| 5. Percent of Family Members Reporting High Cultural Sensitivity of Staff. (Optional) | 26 | 32 | 17.18 | 81.3% |

**** Please report Confidence Intervals at the 95% level. See directions below regarding the calculation of confidence intervals.***

| *State Comments on Data:* | |
|---|---|

**Adult Consumer Surveys**

1. Was the Official 28 Item MHSIP Adult Outpatient Consumer Survey Used? ☑ Yes ☐ No

1.a. If no, which version:

1. Original 40 Item Version ☐ Yes
2. 21-Item Version ☐ Yes
3. State Variation of MHSIP ☐ Yes
4. Other Consumer Survey ☐ Yes

1.b. If other, please attach instrument used.

1.c. Did you use any translations of the MHSIP into another language?

☐ 1. Spanish
2. Other Language:

**Adult Survey Approach:**

**2. Populations covered in survey? (Note all surveys should cover all regions of state)**

☐ 1. All Consumers in State
☑ 2. Sample of MH Consumers

**2.a. If a sample was used, what sample methodology was used?**

- [x] 1. Random Sample
- [x] 2. Stratified Sample
- [ ] 3. Convenience Sample
- 4. Other Sample:

**2.b Do you survey only people currently in services, or do you also Survey Persons no longer in service?**

- [x] 1. Persons Currently Receiving Services
- [x] 2. Persons No Longer Receiving Services

**3. Please Describe the populations included in your sample: (e.g., all adults, only adults with SMI, etc.)**

- [x] 1. All Adult consumers in state
- [ ] 2. Adults with Serious Mental Illness
- [ ] 3. Adults who were Medicaid Eligible or in Medicaid Managed Care

3.4 Other: describe: (for example, if you survey anyone served in the last 3 months, describe that here):

**4. Methodology of collecting data? (Check all that apply)**

| | Self-Administered | Interview |
|---|---|---|
| **Phone** | ☐ Yes | ☐ Yes |
| **Mail** | ☑ Yes | |
| **Face-to-face** | | ☐ Yes |
| **Web-Based** | ☐ Yes | ☐ Yes |

**4.b. Who administered the Survey? (Check all that apply)**

- [x] 1. MH Consumers
- [x] 2. Family Members
- [ ] 3. Professional Interviewers
- [ ] 4. MH Clinicians
- [ ] 5. Non Direct Treatment Staff
- 6. Other: describe:

**5. Are Responses Anonymous, Confidential and/or Linked to other Patient Databases?**

- [x] 1. Responses are Anonymous
- [x] 2. Responses are Confidential
- [ ] 3. Responses are Matched to Client databases

**6. Sample Size and Response Rate**

| | |
|---|---|
| 6a. How many Surveys were Attempted (sent out or calls initiated)? | 3851 |
| 6.b How many survey Contacts were made? (surveys to valid phone numbers or addresses) | |
| 6.c How many surveys were completed? (survey forms returned or calls completed) | 503 |
| 6.d. What was your response rate? (number of Completed surveys divided by number of Contacts) | 13% |

6.e. If you receive "blank" surveys back from consumers (surveys with no responses on them), did you count these survey's as "completed" for the calculation of response rates? ☐ Yes ☑ No

**7. Who Conducted the Survey**

7.a. SMHA Conducted or contracted for the Survey (survey done at state level) ☑ Yes ☐ No

7.b. Local Mental Health Providers/County mental heatlh providers conducted or contracted for the survey (survey was done at the local or regional level) ☐ Yes ☑ No

7.c. Other: Describe:

*** Report Confidence Intervals at the 95% confidence level**

*Note: The confidence interval is the plus-or-minus figure usually reported in newspaper or television opinion poll results. For example, if you use a confidence interval of 4 and 47% percent of your sample picks an answer you can be "sure" that if you had asked the question of the entire relevant population between 43% (47-4) and 51% (47+4) would have picked that answer.*

*The confidence level tells you how sure you can be. It is expressed as a percentage and represents how often the true percentage of the population who would pick an answer lies within the confidence interval. The 95% confidence level means you can be 95% certain; the 99% confidence level means you can be 99% certain. Most researchers use the 95% confidence level.*

*When you put the confidence level and the confidence interval together, you can say that you are 95% sure that the true percentage of the population is between 43% and 51%. (From www.surveysystem.com)*

## Child/Family Consumer Surveys

**1. Was the MHSIP Children/Family Survey (YSS-F) Used?**
*If no, please attach instrument used.*

☑ Yes ☐ No

**1.c. Did you use any translations of the Child MHSIP into another language?**

☐ 1. Spanish
2. Other Languag

**Child Survey Approach:**

**2. Populations covered in survey? (Note all surveys should cover all regions of state)**

☐ 1. All Consumers in State
☑ 2. Sample of MH Consumers

**2.a. If a sample was used, what sample methodology was used?**

☑ 1. Random Sample
☑ 2. Stratified Sample
☐ 3. Convenience Samp
4. Other Sample:

**2.b Do you survey only people currently in services, or do you also Survey Persons no longer in service?**

☑ 1. Persons Currently Receiving Services
☑ 2. Persons No Longer Receiving Services

2a. If yes to 2, please describe how your survey persons no longer receiving services.

**3. Please Describe the populations included in your sample: (e.g., all children, only chidlren with SED, etc.)**

☑ 1. All Child consumers in state
☐ 2. Children with Serious Emotional Disturbances
☐ 3. Children who were Medicaid Eligible or in Medicaid Managed Care

3.4 Other: describe: (for example, if you survey anyone served in the last 3 months, describe that here):

**4. Methodology of collecting data? (Check all that apply)**

| | Self-Administered | Interview |
|---|---|---|
| **Phone** | ☐ Yes | ☐ Yes |
| **Mail** | ☑ Yes | |
| **Face-to-face** | | ☐ Yes |
| **Web-based** | ☐ Yes | ☐ Yes |

**4.b. Who administered the Survey? (Check all that apply)**

☑ 1. MH Consumers
☑ 2. Family Members
☐ 3. Professional Interviewers
☐ 4. MH Clinicians
☐ 5. Non Direct Treatment Staff
6. Other: describe:

**5. Are Responses Anonymous, Confidential and/or Linked to other Patient Databases?**

☑ 1. Responses are Anonymous
☑ 2. Responses are Confidential
☐ 3. Responses are Matched to Client databases

**6. Sample Size and Response Rate**

| | |
|---|---|
| 6a. How many Surveys were Attempted (sent out or calls initiated)? | 418 |
| 6.b How many survey Contacts were made? (surveys to valid phone numbers or addresses) | |
| 6.c How many surveys were completed? (survey forms returned or calls completed) | 39 |
| 6.d. What was your response rate? (number of Completed surveys divided by number of Contacts) | 9% |

6.e. If you receive "blank" surveys back from consumers (surveys with no responses on them), did you count these survey's as "completed" for the calculation of response rates? ☐ Yes ☑ No

**7. Who Conducted the Survey**

7.a. SMHA Conducted or contracted for the Survey (survey done at state level) ☑ Yes ☐ No

7.b. Local Mental Health Providers/County mental heatlh providers conducted or contracted for the survey (survey was done at the local or regional level) ☐ Yes ☑ No

7.c. Other: Describe:

Note:
Number of returned envelopes to HHS as of 10-14-03 due to wrong addresses.

| | |
|---|---|
| Adults MH | 321 |
| Adults SA | 226 |
| Kids MH | 6 |
| Kids SA | 5 |
| Total | 558 |

| Yes | No |
| --- | --- |
| TRUE | FALSE |

FALSE
FALSE
FALSE
FALSE

Spanish

FALSE

FALSE
TRUE

TRUE
TRUE
FALSE

TRUE
TRUE

TRUE
FALSE
FALSE

FALSE FALSE
TRUE
FALSE FALSE

TRUE
TRUE
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TRUE _____ Yes _____ No
TRUE _____ Yes _____ No
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FALSE FALSE

TRUE FALSE
FALSE TRUE

**Table 11a: Consumer Evaluation of Care by Consumer Characteristics: (Optional Table by Race/Ethnicity.)**

Table 11.

Report Year: 2003

State Identifier: Nebraska

| Indicators | Total | | American Indian or Alaska Native | | Asian | | Black or African American | | Native Hawaiian or Other Pacific Islander | | White | | More than One Race Reported | | Other/ Unknown | | Hispanic | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Adult Consumer Survey Results:** | **# Positive** | **Responses** | **# Positive** | **Responses** | **# Positive** | **Responses** | **# Positive** | **Responses** | **# Positive** | **Responses** | **# Positive** | **Responses** | **# Positive** | **Responses** | **# Positive** | **Responses** | **# Positive** | **Responses** |
| Percent Reporting Positively About Ac | 373 | 493 | 14 | 16 | 2 | 3 | 21 | 24 | 3 | 3 | 324 | 431 | 8 | 9 | 11 | 13 | 12 | 13 |
| Percent Reporting Positively About Qu | 371 | 479 | 12 | 15 | 0 | 2 | 20 | 23 | 1 | 3 | 324 | 421 | 8 | 9 | 9 | 12 | 11 | 13 |
| Percent Reporting Positively About Ou | 344 | 481 | 9 | 15 | 2 | 3 | 17 | 24 | 2 | 3 | 302 | 422 | 5 | 8 | 9 | 12 | 11 | 13 |
| Percent Reporting Positively About Pa | 316 | 486 | 12 | 16 | 1 | 4 | 17 | 24 | 1 | 3 | 276 | 424 | 8 | 9 | 8 | 12 | 10 | 13 |
| Percent Reporting Positively About Ge | 393 | 493 | 11 | 16 | 2 | 2 | 22 | 24 | 3 | 3 | 343 | 432 | 7 | 9 | 10 | 13 | 12 | 13 |
| **Child/Adolescent Consumer Survey Results:** | **# Positive** | **Responses** | **# Positive** | **Responses** | **# Positive** | **Responses** | **# Positive** | **Responses** | **# Positive** | **Responses** | **# Positive** | **Responses** | **# Positive** | **Responses** | **# Positive** | **Responses** | **# Positive** | **Responses** |
| Percent Reporting Positively About Access. | 25 | 39 | 2 | 4 | 0 | 0 | 1 | 3 | 0 | 0 | 24 | 35 | 0 | 0 | 1 | 2 | 0 | 1 |
| Percent Reporting Positively About General Satisfaction | 24 | 36 | 3 | 4 | 0 | 0 | 1 | 2 | 0 | 0 | 20 | 33 | 0 | 0 | 2 | 2 | 0 | 0 |
| Percent Reporting Positively About Outcomes. | 22 | 37 | 3 | 4 | 0 | 0 | 2 | 3 | 0 | 0 | 19 | 33 | 0 | 0 | 1 | 2 | 0 | 1 |
| Percent Reporting Positively Participation in Treatment Planning for their Children. | 30 | 36 | 3 | 4 | 0 | 0 | 1 | 2 | 0 | 0 | 26 | 33 | 0 | 0 | 2 | 2 | 0 | 0 |
| Percent Reporting Positively About Cultural Sensitivity of Staff. | 31 | 32 | 2 | 3 | 0 | 0 | 1 | 2 | 0 | 0 | 23 | 29 | 0 | 0 | 2 | 2 | 0 | 0 |

***State Comments***

## Table 12: State Mental Health Agency Profile

The purpose of this profile is to obtain information that provides a context for the data provided in the tables. This profile covers the populations served, services for which the state mental health agency is responsible, data reporting capacities, especially related to duplication of numbers served as well as certain summary administrative information.

| **Table 12** | |
|---|---|
| Report Yr | 2003 |
| State Identifier: | NE |

**Populations Served**

1 **Which of the following populations receive services operated or funded by the state mental health agency? Please indicate if they are included in the data provided in the tables. (Check all that apply.)**

| | ***Populations Covered*** | | ***Included in Data*** | |
|---|---|---|---|---|
| | **State Hospitals** | **Community Programs** | **State Hospitals** | **Community Programs** |
| 1. Aged 0 to 3 | ☐ Yes | ☑ Yes | ☐ Yes | ☑ Yes |
| 2. Aged 4 to 17 | ☑ Yes | ☑ Yes | ☑ Yes | ☑ Yes |
| 3. Adults Aged 18 and over | ☑ Yes | ☑ Yes | ☑ Yes | ☑ Yes |
| 4. Forensics | ☑ Yes | ☐ Yes | ☑ Yes | ☐ Yes |

*State Comments on Data:*

2 **Do all of the adults and children served through the state mental health agency meet the Federal definitions of serious mental illness and serious emotional disturbances?**

NO ☐ Serious Mental Illness

NO ☐ Serious Emotional Disturbances

2.a. If no, please indicate the percentage of persons served for the reporting period who met the federal definitions of serious mental illness and serious emotional disturbance?

| | |
|---|---|
| 2.a.1 Percent of adults meeting Federal definition of SMI: | 47.7% |
| 2.a.2 Percentage of children/adolescents meeting Federal definition of SED | 88.8% |

| | Table 14A | Table 2A | |
|---|---|---|---|
| | SMI/SED Total | Total | % SMI/SED Served |
| 0-3 Years | 230 | 245 | 93.88% |
| 4-12 years | 879 | 1,052 | 83.56% |
| 13-17 years | 1,052 | 1,136 | 92.61% |
| Total 0 - 17 | 2,161 | 2,433 | 88.82% |
| | | | |
| 18-20 years | 318 | 924 | 34.42% |
| 21-64 years | 7,734 | 15,899 | 48.64% |
| 65-74 years | 169 | 346 | 48.84% |
| 75+ years | 87 | 238 | 36.55% |
| Not Available | 0 | 25 | 0.00% |
| Total age 18 + | 8,308 | 17,432 | 47.66% |
| | | | |
| Total | 10,469 | 19,865 | 52.70% |

## 3 Co-Occurring Mental Health and Substance Abuse:

| | | |
|---|---|---|
| 3.a. | What percentage of persons served by the SMHA for the reporting period had a dual diagnosis of mental illness and substance abuse? | |
| 3.a.1 | Percentage of adults served by the SMHA who also has a diagnosis of substance abuse problem | 6.9% |
| 3.a.2. | Percentage of children/adolescents served by the SMHA who also has a diagnosis of substance abuse problem: | 1.5% |

| | | |
|---|---|---|
| 3.b. | What percentage of persons served for the reporting period who met the Federal definitions of adults with SMI and children/adolescents with SED had a dual diagnosis of mental illness and substance abuse | |
| 3.b.1 | Percentage of adults meeting Federal definition of SMI who also has a diagnosis of substance abuse problem | |
| 3.b.2. | Percentage of children/adolescents meeting the Federal definition of SED who also has a diagnosis of substance abuse problem: | |

| | | |
|---|---|---|
| 3b.3 | Please describe how you calculate and count the number of persons with co-occurring disorders | See below. In FY2003, the Nebraska Behavioral Health System served a total of 31,587. There were 2,166 (6.86%) individuals served in some combination of mental health services, substance abuse services, and/or dual services. |

| | FY2003 | |
|---|---|---|
| By Services: | 31,587 | 100.00% |
| MH only | 17,328 | 54.90% |
| SA only | 11,182 | 35.40% |
| Dual only | 426 | 1.30% |
| MH/SA | 1,723 | 5.50% |
| MH/Dual | 15 | 0.00% |
| SA/Dual | 1 | 0.00% |
| MH/SA/Dual | 1 | 0.00% |
| Unknown | 911 | 2.90% |

This chart is the number of individual adults served by type of program.

- The Mental Health Services (MH) include Residential Rehabilitation, ACT, Community Support-MH, Day Treatment, Day Rehabilitation, Vocational Support, Day Support, Outpatient (Individual, Family, Group), and Medication Management.
- The Substance Abuse Services (SA) include Short Term Residential, Therapeutic Community, Halfway House, Community Support-SA, Outpatient (Individual, Family, Group), Detox, and Methadone Maintenance.

| | | |
|---|---|---|
| Number of Children in mental health and substance abuse programs through community based organizations | 2968 | MH or SA or DUAL |
| Number of Children receiving mental health services only through community based organizations | 2412 | MH only |
| Number of Children receiving substance abuse services only through community based organizations | 510 | SA only |
| Number of children receiving both mental health and substance abuse services through community based organizations | 46 | MH and SA |

**4 State Mental Health Agency Responsibilities**

a. Medicaid: Does the State Mental Health Agency have any of the following responsibilities for mental health services provided through Medicaid? (Check All that Apply)

None apply in Nebraska

1. State Medicaid Operating Agency ☐
2. Setting Standards ☐
3. Quality Improvement/Program Compliance ☐
4. Resolving Consumer Complaints ☐
5. Licensing ☐
6. Sanctions ☐
7. Other

**b. Managed Care (Mental Health Managed Care**

| | | | Are Data for these programs reported on URS Tables? |
|---|---|---|---|
| 4.b.1 | Does the State have a Medicaid Managed Care initiative? | ☑ Yes | ☐ Yes |
| 4.b.2 | Does the State Mental Health Agency have any responsibilities for mental health services provided through Medicaid Managed Care? | ☐ Yes | ☐ Yes |

*If yes, please check the responsibilities the SMHA has:*

| | | |
|---|---|---|
| 4.b.3 | Direct contractual responsibility and oversight of the MCOs or BHOs | ☐ Yes |
| 4.b.4 | Setting Standards for mental health services | ☐ Yes |
| 4.b.5 | Coordination with state health and Medicaid agencies | ☐ Yes |
| 4.b.6 | Resolving mental health consumer complaints | ☐ Yes |
| 4.b.7 | Input in contract development | ☐ Yes |
| 4.b.8 | Performance monitoring | ☐ Yes |
| 4.b.9 | Other | |

**5 Data Reporting: Please describe the extent to which your information systems allows the generation of unduplicated client counts between different parts of your mental health system. Please respond in particular for Table 2, which requires unduplicated counts of clients served across your entire mental health system.**

***Are the data reporting in the tables?***

| | | | |
|---|---|---|---|
| 5.a. | **Unduplicated** :counted once even if they were served in both State hospitals and community programs and if they were served in community mental health agencies responsible for different geographic or programmatic areas. | ☐ | |
| 5.b. | **Duplicated:** across state hospital and community programs | ☐ | NO |
| 5.c. | **Duplicated:** within community programs | ☐ | NO |
| 5.d. | **Duplicated:** Between Child and Adult Agencies | ☐ | NO |

5.e. **Plans for Unduplication:** If you are not currently able to provide unduplicated client counts across all parts of your mental health system, please describe your plans to get unduplicated client counts by the end of your Data Infrastructure Grant.

The Mental Health Data Infrastructure Grant funds have been used to contract with a qualified programmer to develop a platform for the unduplicated count between community mental health data, State psychiatric hospital data and Medicaid.

**6 Summary Administrative Data**

| | | | | |
|---|---|---|---|---|
| 6.a. | Report Year | 2003 | | |
| 6.b. | State Identifier | NE | | |
| | *Summary Information on Data Submitted by SMHA:* | | | |
| 6.c. | Year being reported: From: | 1-Jul-02 | to | 30-Jun-03 |
| | Person Responsible for Submission | Jim Harvey | | |
| | Contact Address | Nebraska Department of Health and Human Services<br>Office of Mental Health, Substance Abuse and Addiction Services<br>P.O. Box 98925<br>Lincoln, NE 68509-8925 | | |
| 6.d. | E-mail: | jim.harvey@hhss.state.ne.us | | |
| 6.e. | Contact Phone Number: | 402-479-5125 | | |

**Table 14A. Profile of Persons with SMI/SED served by Age, Gender and Race/Ethnicity**

*This is a developmental table similar to Table 2.A and 2.B. This table requests counts for persons with SMI or SED using the definitions provided by the CMHS. Table 2.A and 2.B included all clients served by publicly operated or funded programs. This table counts only clients who meet the CMHS definition of SMI or SED. For many states, this table may be the same as Tables 2.A and 2.B. For 2003, states should report using the Federal Definitions of SMI and SED if they can report them, if not, please report using your state's definitions of SMI and SED and provide information below describing your state's definition.*

Please enter the "total" in the appropriate row and column and report the data under the categories listed.

| Table 14a. | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Report Year: | 2003 | | | | | | | | | | | | | | | | | |
| State Identifier: | NE | | | | | | | | | | | | | | | | | |
| | Total | | | | American Indian or Alaska Native | | | Asian | | | Black or African American | | | Native Hawaiian or Other Pacific Islander | | | White | |
| | Female | Male | Not Available | Total | Female | Male | Not Available | Female | Male | Not Available | Female | Male | Not Available | Female | Male | Not Available | Female | Male |
| 0-3 Years | 88 | 134 | 8 | 230 | 4 | 0 | 0 | 0 | 0 | 0 | 10 | 18 | 0 | | | | 55 | 85 |
| 4-12 years | 339 | 540 | 0 | 879 | 6 | 16 | 0 | 3 | 2 | 0 | 25 | 41 | 0 | | | | 280 | 450 |
| 13-17 years | 490 | 562 | 0 | 1052 | 24 | 17 | 0 | 2 | 2 | 0 | 26 | 20 | 0 | | | | 406 | 490 |
| 18-20 years | 162 | 156 | 0 | 318 | 2 | 4 | 0 | 2 | 1 | 0 | 4 | 8 | 0 | | | | 140 | 135 |
| 21-64 years | 4,041 | 3688 | 5 | 7734 | 87 | 60 | 0 | 21 | 25 | 0 | 284 | 349 | 0 | | | | 3467 | 3018 |
| 65-74 years | 112 | 56 | 1 | 169 | 1 | 1 | 0 | 2 | 0 | 0 | 2 | 3 | 0 | | | | 98 | 47 |
| 75+ years | 52 | 35 | 0 | 87 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | | | 49 | 34 |
| Not Available | - | 0 | 0 | 0 | | | | | | | | | | | | | | |
| Total | 5,284 | 5,171 | 14 | 10469 | 124 | 98 | - | 30 | 30 | - | 351 | 439 | - | - | - | - | 4,495 | 4,259 |

Comments on Data:

**1. State Definitions Match the Federal Definitions:**

Yes ☐ No ☑ Adults with SMI, if No describe or attach state definition: (See Below)

Diagnoses included in state SMI definition: (See Below)

Yes ☐ No ☑ Children with SED**,** if No describe or attach state definition: (See Below)

Diagnoses included in state SED definition: (See Below)

NE definition for Adults with SMI

Title 204 -- Regulations for Community Mental Health Programs; Chapter 1 – Definitions, 001.33 Persons Disabled By Severe and Persistent Mental Illness:

(a) the individual is age 18 and over;

(b) has a primary diagnosis of schizophrenia, major affective disorders, or other major mental illness under the current edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association. Developmental Disorders, or Psychoactive Substance Use Disorders may be included if they co-occur with the primary mental illnesses listed above; Diagnosis # 295 - 298.9 [Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR) © 2000 American Psychiatric Association. Schizophrenia (295), Mood Disorders including Bipolar and Major Depression (296), Delusional Disorder (297.1), Shared Psychotic Disorder (297.3), Brief Psychotic Disorder (298.8), and Psychotic Disorder NOS (298.9) ["Not Otherwise Specified"].

(c) are at significant risk of continuing in a pattern of either institutionalization or living in a severely dysfunctional way if needed mental health services are not provided, and this pattern has existed for 12 months or longer or is likely to endure for 12 months or longer; and

(d) degree of limitation that seriously interferes with the individual's ability to function independently in an appropriate and effective manner, as demonstra

(1) Vocational/Educational,

(2) Social Skills, or

(3) Activities of Daily Living.

NE definition for Children with SED

Title 204 -- Regulations for Community Mental Health Programs; CHAPTER 1 –DEFINITIONS, 001.07 CHILD OR ADOLESCENT WHO HAS A SEVERE EMOTIONAL DISTURBANCE:

(a) the youth's age must range from birth up to age 18, however, for purpose of transition into adult services, the youth may be age 18 to 20;

(b) the youth must have a mental illness diagnosable under the current edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association,

(c) the condition must be persistent in that it has existed for one year or longer, or is likely to endure for one year or longer; and

(d) the mental illness must result in functional impairments in TWO or more of the following areas:

(i) self-care at an appropriate developmental level,

(ii) developmentally appropriate perception and expressive language,

(iii) learning,

(iv) self-direction, including developmentally appropriate behavioral controls, decision-making, judgment, and value systems, and

(v) capacity for living in a family or family equivalent.

| | Hispanic * *use only if data for Table 14b are not available.* | | | More Than One Race Reported | | | Other Race | | | Race Not Available | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Not Available | Female | Male | Not Available | Female | Male | Not Available | Female | Male | Not Available | Female | Male | Not Available |
| 2 | | | | | | | 7 | 13 | 0 | 12 | 18 | 6 |
| 0 | | | | | | | 15 | 25 | 0 | 10 | 6 | 0 |
| 0 | | | | | | | 27 | 27 | 0 | 5 | 6 | 0 |
| 0 | | | | | | | 8 | 6 | 0 | 6 | 2 | 0 |
| 3 | | | | | | | 138 | 178 | 0 | 44 | 58 | 2 |
| 0 | | | | | | | 4 | 3 | 0 | 5 | 2 | 1 |
| 0 | | | | | | | 2 | 0 | 0 | 1 | 1 | 0 |
| | | | | | | | | | | | | |
| 5 | - | - | - | - | - | - | 201 | 252 | - | 83 | 93 | 9 |

**Table 14B. Profile of Persons with SMI/SED served by Age, Gender and Race/Ethnicity**

*definition of SMI or SED should be the total as indicated in Table 14 A.*

Please enter the "total" in the appropriate row and column and report the data under the categories listed.

| | |
|---|---|
| Table 14b. | |
| Report Year: | 2003 |
| State Identifier: | NE |

| | Not Hispanic or Latino | | | Hispanic or Latino | | | Hispanic or Latino Origin Not Available | | | Total | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Female | Male | Not Available | Female | Male | Not Available | Female | Male | Not Available | Female | Male | Not Available | Total |
| 0 - 3 Years | 66 | 103 | 1 | 9 | 10 | 0 | 13 | 21 | 7 | 88 | 134 | 8 | 230 |
| 4 - 12 years | 309 | 504 | 0 | 22 | 32 | 0 | 8 | 4 | 0 | 339 | 540 | - | 879 |
| 13 - 17 years | 451 | 523 | 0 | 27 | 28 | 0 | 11 | 12 | 0 | 489 | 563 | - | 1,052 |
| 18 - 20 years | 150 | 140 | 0 | 7 | 10 | 0 | 5 | 6 | 0 | 162 | 156 | - | 318 |
| 21-64 years | 3785 | 3437 | 2 | 133 | 121 | 0 | 123 | 130 | 3 | 4,041 | 3,688 | 5 | 7,734 |
| 65-74 years | 107 | 52 | 0 | 3 | 3 | 0 | 2 | 1 | 1 | 112 | 56 | 1 | 169 |
| 75+ years | 51 | 32 | 0 | 0 | 0 | 0 | 1 | 3 | 0 | 52 | 35 | - | 87 |
| Not Available | | | | | | | | | | - | - | - | - |
| Total | 4,919 | 4,791 | 3 | 201 | 204 | - | 163 | 177 | 11 | 5,283 | 5,172 | 14 | 10,469 |

State Comments on Data:

*Table edits*

**Table 15. Living Situation Profile:**

**Number of Clients in Each Living Situation as Collected by the Most Recent Assessment in the Reporting Period**
**All Mental Health Programs by Age, Gender, and Race/Ethnicity**

*Please provide unduplicated counts, if possible. This table provides an aggregate profile of persons served in the reporting year. The reporting year should be the latest state fiscal year for which data are available. This profile is based on a client*
Please enter the "total" for the appropriate row and column and report the data under the Living Situation categories listed.

| Table 15. | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Report Year: | 2003 | | | | | | | | | |
| State Identifier: | NE | | | | | | | | | |
| | **Private Residence** | **Foster Home** | **Residential Care** | **Crisis Residence** | **Children's Residential Treatment** | **Institutional Setting** | **Jail/ Correctional Facility** | **Homeless/ Shelter** | **Other** | **Not Available** |
| 0-17 | 2203 | 55 | 31 | | | 3 | 13 | 28 | 56 | 65 |
| 18-64 | 12818 | 29 | 436 | | | 371 | 242 | 1376 | 1434 | 119 |
| 65 + | 389 | 2 | 109 | | | 4 | 3 | 4 | 55 | 16 |
| Not Available | 0 | 0 | 0 | | | 0 | 0 | 0 | 0 | 4 |
| TOTAL | 15410 | 86 | 576 | | | 378 | 258 | 1408 | 1545 | 204 |
| **Grand Total** | **19865** | | | | | | | | | |
| Female | 8108 | 44 | 278 | | | 146 | 66 | 553 | 746 | 97 |
| Male | 7297 | 42 | 298 | | | 232 | 192 | 855 | 798 | 83 |
| Not Available | 5 | 0 | 0 | | | 0 | 0 | 0 | 1 | 24 |
| TOTAL | 15410 | 86 | 576 | | | 378 | 258 | 1408 | 1545 | 204 |
| **Grand Total** | **19865** | | | | | | | | | |
| American Indian/Alaskan Native | 353 | 5 | 7 | | | 6 | 17 | 39 | 32 | 1 |
| Asian | 78 | 0 | 2 | | | 4 | 2 | 9 | 8 | 1 |
| Black/African American | 854 | 8 | 43 | | | 24 | 40 | 218 | 121 | 12 |
| Hawaiian/Pacific Islander | | | | | | | | | | |
| White/Caucasian | 13287 | 65 | 500 | | | 314 | 189 | 1085 | 1291 | 62 |
| Hispanic * | | | | | | | | | | |
| More than One Race Reported | | | | | | | | | | |
| Other Race/Ethnicity | 666 | 6 | 15 | | | 20 | 10 | 39 | 63 | 25 |
| Race/Ethnicity Not Available | 172 | 2 | 9 | | | 10 | 0 | 18 | 30 | 103 |
| TOTAL | 15410 | 86 | 576 | | | 378 | 258 | 1408 | 1545 | 204 |
| **Grand Total** | **19865** | | | | | | | | | |
| Hispanic or Latino Origin | 735 | 2 | 12 | | | 9 | 19 | 44 | 40 | 3 |
| Non Hispanic or Latino Origin | 14200 | 81 | 549 | | | 352 | 237 | 1253 | 1430 | 88 |
| Hispanic or Latino Origin Not Available | 475 | 3 | 15 | | | 17 | 2 | 111 | 75 | 113 |
| TOTAL | 15,410 | 86 | 576 | | | 378 | 258 | 1,408 | 1,545 | 204 |
| Comments on Data: | | | | | | | | | | |

| | |
|---|---|
| | *Unduplicated data, other contains Other Residential and Other Psychiatric Hospital* |

* Hispanic: Only use the "Hispanic" row under Race if data for Hispanic as a Ethinic Origin are not available

***Optional Table - To be developed by the Living Situation WorkGroup. We are currently discussing the methodology for collecting and reporting***

***Living Situation Definitions*** :

**Private Residence:** Individual lives in a house, apartment, trailer, hotel, dorm, barrack, and/or Single Room Occupancy (SRO).

**Foster Home:** Individual resides in a Foster Home. A Foster Home is a home that is licensed by a County or State Department to provide foster care to

**Residential Care:** Individual resides in a residential care facility. This level of care may include a Group Home, Therapeutic Group Home, Board and

**Crisis Residence:** A residential (24 hours/day) stabilization program that delivers services for acute symptom reduction and restores clients to a pre-crisis

**Children's Residential Treatment Facility:** Children and Youth Residential Treatment Facilities (RTF's) provide fully-integrated mental health treatment

**Institutional Setting:** Individual resides in an institutional care facility with care provided on a 24 hour, 7 day a week basis. This level of care may include

**Jail/ Correctional Facility:** Individual resides in a Jail and/or Correctional facility with care provided on a 24 hour, 7 day a week basis. This level of care

**Homeless**: A person is considered homeless if he/she lacks a fixed, regular, and adequate nighttime residence and/or his/her primary nighttime residency is:

A) A supervised publicly or privately operated shelter designed to provide temporary living accommodations,
B) An institution that provides a temporary residence for individuals intended to be institutionalized, or
C) A public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings (e.g., on the street).

**Unavailable:** Information on an individual's residence is not available.

# TABLE 17:

## DEFINITIONS

**Family Psycho**
Offered as part
outcome throug
suffering of fam
Psychoeducatio
Psychoeducatio
and problem-sol

**Integrated Trea**
Dual diagnosis t
clinical encounte
setting, provide
words, the careg
with a dual di
recommendatior
dual diagnosis ir

**Illness Manage**
Includes a broac
illness, often w
symptoms, and
tailoring, early w

## INSTRUCTIONS

1 Please ente
during the re

2 Please ente
sex and rac

3 States are u
fidelity is be

# DEFINITIONS AND INSTRUCTIONS

**education:**
of an overall clinical treatment plan for individuals with mental illness to achieve the best possible
h the active involvement of family members in treatment and management and to alleviate the
ily members by supporting them in their efforts to aid the recovery of their loved ones. Family
n programs may be either multi-family or single-family focused. Core characteristics of family
n programs include the provision of emotional support, education, resources during periods of crisis,
lving skills.

**tment for Co-occurring Disorders**
treatments combine or integrate mental health and substance abuse interventions at the level of the
er. Hence, integrated treatment means that the same clinicians or teams of clinicians, working in one
appropriate mental health and substance abuse interventions in a coordinated fashion. In other
givers take responsibility for combining the interventions into one coherent package. For the individual
agnosis, the services appear seamless, with a consistent approach, philosophy, and set of
ns. The need to negotiate with separate clinical teams, programs, or systems disappears. The goal of
nterventions is recovery from two serious illnesses.

**ment / Recovery:**
d range of health, lifestyle, and self-assessment and treatment behaviors by the individual with mental
ith the assistance and support of others, so they are able to take care of themselves, manage
learn ways to cope better with their illness. Self management includes psychoeducation, behavioral
arning sign recognition, coping strategies, social skills training, and cognitive behavioral treatment.

r the unduplicated number of adults with serious mental illness who received each service category
eporting year.

r the unduplicated number of adults with serious mental illness (or children with SED) in each age,
e/ehtnicity category that received any service during the year.

sing a variety of instruments to monitor fidelity, some of which are more standardized than others. If
ing monitored in your state, pleas indicate the instrument being used for each service category.

# Table 17

## 17: ADULTS WITH SERIOUS MENTAL ILLNESS RECEIVING SPECIFIC SERVICES DURING THE

| State | NE | | |
|---|---|---|---|
| Reporting Year | 2003 | | |
| | ADULTS WITH SERIOUS MENTAL ILLNESS | | |
| | Receiving Family | Receiving Integrated | Receiving Illness |
| **Age** | | | |
| 18-20 | | 19 | |
| 21-64 | | 443 | |
| 65-74 | | 0 | |
| 75+ | | 0 | |
| Not Available | | 0 | |
| TOTAL | | 462 | |
| | | | |
| **Gender** | | | |
| Female | | 229 | |
| Male | | 232 | |
| Not Available | | 1 | |
| TOTAL | | 462 | |
| | | | |
| **Race** | | | |
| American Indian/ Alaskan Native | | 13 | |
| Asian | | 0 | |
| Black/African American | | 44 | |
| Hawaiian/Pacific Islander | | | |
| White | | 391 | |
| Hispanic* | | | |
| More than one race | | | |
| Other | | 14 | |
| Unknown | | 0 | |
| TOTAL | | 462 | |

| **Hispanic/Latino Origin** | | | |
|---|---|---|---|
| Hispanic/Latino Origin | | 12 | |
| Non Hispanic/Latino | | 445 | |
| Hispanic/Latino Origin Not Available | | 5 | |
| TOTAL | | 462 | |

| Do You Monitor Fidelity for this Service? | Yes ☐ | No ☐ | Yes ☐ | No ☐ | Yes ☐ | No ☐ |
|---|---|---|---|---|---|---|

IF YES,

| What Fidelity Measure Do You Use? | | | |
|---|---|---|---|
| Who Measures Fidelity? | | | |
| How often is Fidelity Measured? | | | |

** Only Report Hispanic as part of the "Race Category" if you are not able to report using the Federal 2 Question Format*

* Hispanic is part of the total served. Yes ☐ No ☐

Comments on Data:

# TABLE 18: DEFINITIONS AND INSTRUCTIONS

**DEFINITIONS**

**Adults with Schizophrenia Receiving New Generation Medications**

**Adults with a primary diagnosis of schizophrenia who received Clozapine, Quetapine, Olanzonpine, Risperdone or Ziprasidone during the reporting year in the specified setting.**

**INSTRUCTIONS**

1 Please enter the unduplicated number of adults with schizophrenia that received the new generation medications in each setting.

2 Please enter the unduplicated number of all adults with a primary diagnosis of schizophrenia that received any service in the specified setting during the year.

3 Some clinical guidelines used:
- American Psychiatric Association
- Consensus "Tri-University" Project
- Schizophrenia Patient Outcome Research Team (PORT)
- Texas Medications Algorithm Project (TMAP)

# Table 18

## TABLE 18: ADULTS WITH SCHIZOPHRENIA RECEIVING NEW GENERATION MEDICATIONS

| State | NE |
|---|---|
| Reporting Year | 2003 |

| | STATE HOSPITALS | | COMMUNITY SETTINGS | | STATE MENTAL HEALTH | |
|---|---|---|---|---|---|---|
| | Unduplicated N of Adults with Schizophrenia Receiving New Generation Meds | Unduplicated N of Adult with Schizophrenia Served | Unduplicated N of Adults with Schizophrenia Receiving New Generation Meds | Unduplicated N of Adult with Schizophrenia Served | Unduplicated N of Adults with Schizophrenia Receiving New Generation Meds | Unduplicated N of Adult with Schizophrenia Served |
| **Age** | | | | | | |
| 18-20 | | | | 55 | | |
| 21-64 | | | | 2502 | | |
| 65-74 | | | | 74 | | |
| 75+ | | | | 18 | | |
| Not Available | | | | 0 | | |
| TOTAL | | | | 2649 | | |
| **Gender** | | | | | | |
| Female | | | | 1081 | | |
| Male | | | | 1564 | | |
| **Race** | | | | | | |
| American Indian/ Alaskan | | | | 45 | | |
| Asian | | | | 25 | | |
| Black/African American | | | | 332 | | |
| Hawaiian/Pacific Islander | | | | | | |
| White | | | | 2068 | | |
| Hispanic* | | | | | | |
| More than one race | | | | | | |
| Other | | | | 125 | | |
| Unknown | | | | 54 | | |
| **Hispanic/Latino Origin** | | | | | | |
| Hispanic/Latino Origin | | | | 94 | | |
| Non Hispanic/Latino | | | | 2398 | | |
| Hispanic origin not available | | | | 157 | | |

| Are specific clinical guidelines followed? | Yes | No | Yes | No | Yes | No |
|---|---|---|---|---|---|---|
| | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

| If Yes, which one? | | | | | | |
|---|---|---|---|---|---|---|

* Hispanic is part of the total served. Yes ☐ No ☐

** Only Report Hispanic as part of the "Race Category" if you are not able to report using the Federal 2 Question Format*

Comments on Data: Unduplicated N of Adult with Schizophrenia Served means those individuals with a diagnosis of schizophrenia 295, s

**Table 20A - Non-Forensic (Voluntary and Civil-Involuntary Patients)**

**READMISSION TO ANY STATE PSYCHIATRIC INPATIENT HOSPITAL WITHIN 30/180 DAYS OF DISCHARGE**

| State: Nebraska | | | | | |
|---|---|---|---|---|---|
| Reporting Year: 2002 | | | | | |
| | Total number of Discharges in Year | Number of Readmissions to ANY State Psychiatric Hospital within: | | Percent Readmitted | |
| | | 30 days | 180 days | 30 days | 180 days |
| **Total Patients** | 1,058 | 57 | 168 | 5.4% | 15.9% |
| **Age:** | | | | | |
| 0-3 years | 0 | 0 | 0 | --- | --- |
| 4-12 years | 0 | 0 | 0 | --- | --- |
| 13-17 years | 105 | 9 | 19 | 8.6% | 18.1% |
| 18-20 years | 86 | 1 | 10 | 1.2% | 11.6% |
| 21-64 years | 839 | 47 | 135 | 5.6% | 16.1% |
| 65-74 years | 19 | 0 | 4 | 0.0% | 21.1% |
| 75+ years | 9 | 0 | 0 | 0.0% | 0.0% |
| Not Available | 0 | 0 | 0 | --- | --- |
| **Gender:** | | | | | |
| Female | 402 | 24 | 66 | 6.0% | 16.4% |
| Male | 656 | 33 | 102 | 5.0% | 15.5% |
| Not Available | 0 | | | --- | --- |
| **Race:** | | | | | |
| American Indian/ Alaskan Native | 27 | 0 | 3 | 0.0% | 11.1% |
| Asian | 5 | 0 | 0 | 0.0% | 0.0% |
| Black/African American | 101 | 9 | 21 | 8.9% | 20.8% |
| Hawaiian/Pacific Islander | 0 | 0 | 0 | --- | --- |
| White | 852 | 45 | 138 | 5.3% | 16.2% |
| Hispanic | 41 | 2 | 3 | 4.9% | 7.3% |
| More than one race | 13 | 0 | 0 | 0.0% | 0.0% |
| Other | 14 | 1 | 3 | 7.1% | 21.4% |
| Not Available | 5 | 0 | 0 | 0.0% | 0.0% |
| **Hispanic/Latino Origin:** | | | | | |
| Hispanic/Latino Origin | | | | | |
| Non Hispanic/Latino | | | | | |
| Not Available | | | | | |

**Table 20B - Forensic Patients**

**READMISSION TO ANY STATE PSYCHIATRIC INPATIENT HOSPITAL WITHIN 30/180 DAYS OF DISCHARGE**

| State: Nebraska | | | | | |
|---|---|---|---|---|---|
| Reporting Year: 2002 | | | | | |
| | Total number of Discharges in Year | Number of Readmissions to ANY State Psychiatric Hospital within: | | Percent Readmitted | |
| | | 30 days | 180 days | 30 days | 180 days |
| **Total Patients** | 91 | 1 | 10 | 1.1% | 11.0% |
| **Age:** | | | | | |
| 0-3 years | 0 | 0 | 0 | --- | --- |
| 4-12 years | 0 | 0 | 0 | --- | --- |
| 13-17 years | 1 | 0 | 0 | 0.0% | 0.0% |
| 18-20 years | 6 | 0 | 0 | 0.0% | 0.0% |
| 21-64 years | 84 | 1 | 10 | 1.2% | 11.9% |
| 65-74 years | 0 | 0 | 0 | --- | --- |
| 75+ years | 0 | 0 | 0 | --- | --- |
| Not Available | 0 | 0 | 0 | --- | --- |
| **Gender:** | | | | | |
| Female | 0 | 0 | 0 | --- | --- |
| Male | 91 | 1 | 10 | 1.1% | 11.0% |
| Not Available | 0 | 0 | 0 | --- | --- |
| **Race:** | | | | | |
| American Indian/ Alaskan Native | 2 | 0 | 0 | 0.0% | 0.0% |
| Asian | 0 | 0 | 0 | --- | --- |
| Black/African American | 19 | 0 | 3 | 0.0% | 15.8% |
| Hawaiian/Pacific Islander | 0 | 0 | 0 | --- | --- |
| White | 67 | 1 | 6 | 1.5% | 9.0% |
| Hispanic | 3 | 0 | 1 | 0.0% | 33.3% |
| More than one race | 0 | 0 | 0 | --- | --- |
| Other | 0 | 0 | 0 | --- | --- |
| Not Available | 0 | 0 | 0 | --- | --- |
| **Hispanic/Latino Origin:** | | | | | |
| Hispanic/Latino Origin | | | | | |
| Non Hispanic/Latino | | | | | |
| Not Available | | | | | |